S. HRG. 104–44

HEALTH CARE LIABILITY REFORM AND QUALITY ASSURANCE ACT OF 1995

HEARING

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

ON

S. 454

TO REFORM THE HEALTH CARE LIABILITY SYSTEM AND IMPROVE HEALTH CARE QUALITY THROUGH THE ESTABLISHMENT OF QUALITY ASSURANCE PROGRAMS

MARCH 28, 1995

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CONTENTS

STATEMENTS

TUESDAY, MARCH 28, 1995

	Page
Kassebaum, Hon. Nancy L., Chairman of the committee, opening statement ...	1
Kennedy, Hon. Edward M., a U.S. Senator from the State of Massachusetts, opening statement ...	2
Pell, Hon. Claiborne, a U.S. Senator from the State of Rhode Island, prepared statement ...	3
Wellstone, Hon. Paul, a U.S. Senator from the State of Minnesota, prepared statement ...	3
McConnell, Hon. Mitch, a U.S. Senator from the State of Kentucky; and Hon. Joseph I. Lieberman, a U.S. Senator from the State of Connecticut ...	5
Prepared statement of Senator Lieberman ...	9
Lindenthal, Lynne and Luke, Mercer County, New Jersey ...	19
Dickey, Nancy W., M.D., Richmond, TX, vice chair, board of trustees, American Medical Association; Thomas A. Scully, president and chief executive officer, Federation of American Health Systems, Washington, DC; and Laura Wittkin, executive director, National Center for Patients' Rights, New York, NY ...	25
Prepared statements of:	
Dr. Dickey ...	27
Mr. Scully ...	33
Ms. Wittkin ...	51
American Bar Association, Philip H. Corboy, chair, Special Committee on Medical Professional Liability, prepared statement ...	88
American Academy of Family Physicians, prepared statement ...	104

HEALTH CARE LIABILITY REFORM AND QUALITY ASSURANCE ACT

TUESDAY, MARCH 28, 1995

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 9:30 a.m., in room SD–430, Dirksen Senate Office Building, Senator Nancy Landon Kassebaum (chairman of the committee) presiding.

Present: Senators Kassebaum, Jeffords, Coats, Gregg, DeWine, Ashcroft, Abraham, Gorton, Kennedy, Pell, Simon, and Wellstone.

OPENING STATEMENT OF SENATOR KASSEBAUM

The CHAIRMAN. The hearing will please come to order.

Before introducing our first panel, who of course are the distinguished cosponsors of this legislation, I would just like to give a brief opening statement.

The Health Care Liability Reform and Quality Assurance Act that we will be considering this morning is an important piece of legislation. Most Americans agree that the medical liability system is badly in need of reform. We have acknowledged that in many ways, on and off, for a number of years and yet have not found a means to really address it in a way that seemed to move the issue forward constructively.

The current system carries great human and economic costs. It rewards lawyers more richly than injured patients; it forces providers to perform costly and unnecessary procedures that prevent access to care in areas where care is needed most, and it fails adequately to compensate those who are truly injured by medical malpractice.

I am not going to go through a list of facts because I think Senator McConnell and Senator Lieberman will touch on all of those. But the legislation that we are considering today takes an important step toward returning common sense and reason to a system that I believe is seriously out of balance.

The purpose of the legislation is straightforward: individuals who are genuinely injured should be fairly compensated, and individuals who are genuinely at fault should pay their fair share. Again, I am going to leave the details of the legislation up to our first witnesses and the distinguished cosponsors of this legislation.

Senator Kennedy.

Opening Statement of Senator Kennedy

Senator Kennedy. Thank you, Madam Chairman.

I want to commend Senator Kassebaum for convening this hearing on the important issue of health care liability and the quality of care. The comprehensive health reform bill reported by the Labor Committee last year included major proposals to enhance quality and improve the way the legal system deals with malpractice claims. Many of these liability reform proposals enjoyed bipartisan support, as did other major aspects of the health reforms.

I am hopeful that in this session of the Congress, we will be able to enact as many of these reforms as possible.

Malpractice reforms are already taking place at the State level. This is appropriate because the States are best situated to weed out the few bad apples in the medical profession who cause so much of the malpractice.

Any Federal legislation in this area should be balanced to take account of the concerns of both doctors and consumers. The health bill reported favorably by the Labor Committee last year proposed, for example, mandatory alternative dispute resolution, limits on contingency fees of lawyers, reduction of awards when plaintiffs are compensated for their injuries by workmen's compensation or other sources, and periodic payment of future damages.

We gave the Secretary of Health and Human Services authority in that bill to make grants to States to determine the effectiveness of alternative approaches such as enterprise liability, practice guidelines and no-fault liability.

The bill before us today includes several of these worthwhile ideas but it is flawed in other respects. It preempts State laws that benefit patients and consumers while leaving in place State laws that are more favorable to insurance companies. In my view, any preemption of State laws should be even-handed.

The bill caps punitive damages. Such caps disadvantage the most seriously harmed patients. Punitive damages are intended to penalize the most outrageous forms of misconduct.

The bill eliminates the longstanding common law doctrine of joint and several liability, an important protection for injured patients.

The bill completely immunizes obstetricians from malpractice liability if they have not previously treated the patient, even if the doctor's conduct was grossly negligent or reckless. I think most would want to have the doctors who have been treating the patients, deliver babies, rather than immunize other doctors which creates an incentive for them to go in and deliver the babies. I do not understand that provision.

The bill raises the burden of proof in medical malpractice trials to proof beyond a reasonable doubt, the standard of proof required in criminal proceedings. No other aspect of tort law imposes such a pro-defendant standard, and there is no justification for it in health care liability.

As our consideration on this issue in the Congress moves forward, I hope we can resolve these concerns fairly and return to the concepts on which we reached bipartisan agreement last year.

I look forward to the testimony.

The CHAIRMAN. Before we begin we will insert for the record prepared statements of Senators Pell and Wellstone.

[The prepared statements of Senators Pell and Wellstone follow:]

PREPARED STATEMENT OF SENATOR PELL

Madame Chairman, I thank you for holding today's hearing on the issue of medical liability.

This has long been a subject of considerable interest to me. And I do believe that there may well be a Federal role in reforming our medical liability system.

But there have been complaints from people of good faith on all sides of this issue that the debate is too often based on anecdotes, impressions, or just plain myth—and not on fact.

I hope that this hearing will elicit the real facts in this debate and thereby help lay to rest any sense that this committee is reacting in a "knee-jerk" fashion, without substantive support for its actions. I hope that we can find a way to reform our medical malpractice laws without jeopardizing patient safety or patient confidence in the medical system.

I thank you, Madam Chairman, for holding this interesting hearing and look forward to the testimony of today's witnesses.

PREPARED STATEMENT OF SENATOR WELLSTONE

There are many myths about the medical malpractice issue that confuse the debate, and lead us to lose track of the goals of this tort law system: to deter medical practitioners from committing malpractice, and to fairly compensate victims of malpractice for their injuries, and resultant physical, emotional, and economic losses.

Any plan for health care liability reform should improve the fairness of our current health care liability system for patients and providers and ensure that individuals with meritorious health care injury claims receive fair and adequate compensation. Reform should not be equated to insulating negligent doctors and keeping malpractice victims out of court. Many of the proposals that we have seen recently that are advanced by insurance and medical lobbies do not meet our most fundamental goals.

Caps on noneconomic (pain and suffering) or punitive damages do not prevent excessive awards in themselves—they only prevent compensation for the relatively rare awards at the upper end of the scale that are made for particularly egregious malpractice. The General Accounting Office has estimated that only 2 percent of noneconomic awards damage awards are above $200,000. Individuals who are the victims of egregious malpractice are generally the most in need of compensation. While limiting awards for pain and suffering seems appealing, it would hurt the very people who deserve compensation most. In addition, caps on punitive damages also disproportionately affect victims of gross negligence or malice, and thus would unfairly penalize these most deserving of victims. These caps would disproportionately affect women, who are awarded 68 percent of the punitive damages verdicts, often as a result of sexual abuse by a provider. Because such awards are rare, they add little to the costs of the system.

Elimination of joint liability sounds reasonable on the surface, holding each party that contributes to malpractice responsible only for the proportion of the malpractice to which they contributed. Unfortunately, however, if one of the parties declares bankruptcy, the victim is left holding the bag. Although providers of health care cannot always be "their brother's keeper", it is unfair to ask victims to pay the consequences if a wrongdoer is unable to pay. The care givers should step to the plate and take responsibility for assuring that the patient receives all they have coming.

There is no question that obstetricians sued for malpractice more frequently than any other physicians. The tragedy of birth injuries can shatter the lives of the newborn and its family, with often devastating consequences. Many adverse birth events are not malpractice, and could be avoided if prenatal care were provided, and obstetricians were familiar with the patient and her medical circumstances prior to delivery. On the other hand, negligence should not be more likely to occur in women not seen previously by an obstetrician, than in regularly seen patients. As long as the same standard of negligence is applied to all patients, special protection for the obstetrician should not be needed.

One of the major problems with medical malpractice is the large number of cases that are brought to court and subsequently found to be without merit. A method of screening cases, using some form of Alternative Dispute Resolution (ADR), is reasonable. This process, however, must be carefully designed to be timely and fair. Patients who are dissatisfied with the outcome of ADR must have the option of pursuing their cases in court without undue restrictions or requirements for excessive standards of proof.

In this debate over medical malpractice, it is easy to lose sight of the fact that only a tiny fraction of the episodes of malpractice that occur are made known to the patient, and even fewer result in malpractice cases. Studies by Troyen Brennan, a physician and attorney at Harvard Medical School, and published in the New England Journal of Medicine showed that adverse events occurred in 3.7 percent of hospitalizations, with 27.6 percent of these due to negligence and resulting in permanent disability or death in a significant number of cases. In addition, adverse events were more common in the elderly, some of our most vulnerable citizens. In subsequent studies, it was shown that fewer than 1 in 8 episodes of negligence result in a malpractice action.

It is clear that medical malpractice is a serious problem for patients, and that its impact on health care providers has been more difficult to quantify. There is little evidence that the threat of malpractice or large settlements has had a deterrent effect on the occurrence of malpractice. In addition, many of the proposed "reforms" would merely penalize the innocent victims of negligence. True reform would instead assure that all cases of true malpractice are disclosed to victims; that frivolous malpractice claims are discarded quickly; that true claims are settled in a fair, timely fashion; that monetary awards go to the victims and not attorneys or insurance companies; and that the amounts of the awards are fair, reasonable, and sufficient to cover the medical, emotional, and economic consequences of being a victim of negligence.

The CHAIRMAN. Senator McConnell.

STATEMENTS OF HON. MITCH McCONNELL, A U.S. SENATOR FROM THE STATE OF KENTUCKY; AND HON. JOSEPH I. LIEBERMAN, A U.S. SENATOR FROM THE STATE OF CONNECTICUT

Senator MCCONNELL. Madam Chairwoman, I thank you very much for holding this hearing on the Health Care Liability Reform and Quality Assurance Act of 1995, which has been introduced by yourself, Senator Lieberman, and myself.

I certainly appreciate the promptness with which we are dealing with this issue because I think it is an extremely important issue affecting a great many Americans.

Last year, Congress rejected the dismantling of the finest health care system in the world, but in the process of last year's health care debate, many of us concluded there were some issues of reform that needed to be addressed. Among the most important is reform of the medical liability system.

The McConnell-Lieberman-Kassebaum bill has as its goals promoting patient safety, compensating those injured fully and fairly, but without enriching lawyers, making health care more accessible, containing costs, strengthening the doctor-patient relationship, and encouraging medical innovation.

Our present liability system does none of those things. Injured patients looking at the overall tort system get about 43 cents of every dollar spent in our liability system. Too many people cannot get the health care they need. For example, half a million rural women cannot find a nearby obstetrician to deliver their babies. And doctors, too, often play defense in the examining room because they face a greater than one-in-three chance of being sued in the course of their careers.

The changes we propose would begin to solve these problems and restore fairness, certainty and predictability to the liability system. I will highlight some of the provisions.

First, our bill applies to all defendants brought in a medical malpractice case, including the doctor, hospital, and drug or device manufacturer. The standards must be the same for all defendants, or else we will create more litigation when injured parties bring multiple lawsuits for the same negligence.

Second, the standards set forth in the bill are a floor—a floor—not a ceiling. State laws which provide additional defenses or limitations will still be valid. And our intention is to allow States to continue experimenting with reforms.

Third, the bill eliminates joint liability for noneconomic and punitive damages. Liable parties should only be responsible for their proportionate share of the injury caused. This will put an end to the practice of joining a party because of deep pockets.

Fourth, we reform punitive damages and the collateral source rule. Punitive damages will have to be specifically pleaded and proved, and when they are awarded, it will be done in an amount proportionate to the harm caused—the greater of three times economic damages, or $250,000.

To prevent double recovery for the same injury and to eliminate the overuse and abuse of the health care system, our bill requires damages to be reduced by amounts the injured person receives

from other sources, such as insurance or wage continuation programs.

Fifth, we encourage State-based alternative dispute resolution, including early offer, which would give the injured party 100 percent of all economic losses in return for refraining from a lawsuit. This was an idea which originated, interestingly enough, with Congressman Dick Gephardt 10 years ago, and in a different form, is in a bill that Senator Abraham and I are pushing. We think the early offer mechanism has a lot of potential.

Sixth, we offer protection from liability to obstetricians who see a baby only for the first time when delivering the baby; and we require that a certificate of merit filed by a qualified specialist accompany the lawsuit.

Let me mention our patient protection provisions, and I know that Senator Lieberman will address the biomaterials provisions.

Our bill requires that States establish quality assurance programs funded by 50 percent of all punitive damage awards. Quality assurance programs would be used in the licensing and certifying of health care practitioners as well as in reducing malpractice costs for volunteer providers in medically underserved areas.

In addition, our bill requires those who provide health care and their insurers to participate in risk management programs at least once every 3 years. And the bill gives public access to the National Practitioner Data Bank, but only for that information which refers to disciplinary action, such as a revocation of a license against a health care provider.

Let me conclude with an issue we left out of our bill, and that is the cap on noneconomic damages, or pain and suffering. For too long, the debate on legal reform, including malpractice, has focused exclusively on the injured in a lawsuit. Those of us who have advocated reform have been unfairly accused of trying to limit compensation for those victims of injury. We have tried to argue that we do not want to limit compensation, that we want to restore fairness. But when our bills have contained caps on damages, that argument has not been heard.

The truth is, Senator Kassebaum, in our litigious society, a doctor or a small business owner has as much chance of being a victim of a lawsuit as an individual has of being a victim in a lawsuit. And we have never been able to have the debate on these terms. We think that there are many significant reforms that can be undertaken, short of capping damages for pain and suffering.

Our opponents, frankly, cannot criticize us for appearing to limit victims' compensation if you stay away from limitations on pain and suffering.

Our bill is about fairness, eliminating the lottery of lawsuits and establishing a system where the truly injured get justly compensated. And let me reiterate the point on pain and suffering one more time.

With regard to those damages that are designed to make the plaintiff whole, the philosophy of this bill is that there should not be a cap on damages—not a cap on economic, not a cap on pain and suffering—although the physicians would like to have a cap on pain and suffering. We do think there should be a cap on punitive damages, and my own view—and I know this is shared by Senator

Abraham—is that we really ought to have comprehensive tort reform. Even though we are working on this medical malpractice bill, ultimately, our goal should be to have consistency and a comprehensive civil justice reform bill for all America. And it seems to me that this portion ought to fit comfortably with the larger issue, and that is why we have felt that a limitation on pain and suffering would not be consistent if done only for this particular profession.

Let me just conclude before handing it over to Senator Lieberman, that obviously, our Nation is suffering from "lawsuititis," as one editorial cartoonist called it, and it seems to me this is a good opportunity to begin to take the cure—a strong dose of legal reform.

Thank you, Senator Kassebaum.

The CHAIRMAN. Thank you very much, Senator McConnell.

I think it is terribly important also to take note that this is a bipartisan effort, led by two people, Senator Lieberman and Senator McConnell, who are very knowledgeable in this field of tort reform and have given a lot of thought and attention to it in a very thoughtful manner.

I am pleased myself that it is a bipartisan effort because I think it lends strength to the dedication of those who are involved and want to find constructive answers.

Senator MCCONNELL. Could I say one other thing, Senator Kassebaum? I have to go and chair a hearing at 10 o'clock, but I am interested in the questions. I have had some discussions with Senator Abraham, and I do want to answer questions, so I would be happy to receive those in writing and would like to answer them for the record if they come after I leave.

The CHAIRMAN. All right. Thank you very much.

Senator Lieberman.

Senator LIEBERMAN. Thank you, Madam Chairman, and thank you for your kind words.

I too am proud to be a cosponsor with yourself and with Senator McConnell, and I am very happy that this is a bipartisan effort, which obviously it should be; this is not a problem that divides or should divide along partisan lines. We are greatly enhanced by your cosponsorship of this bill, which addresses the inefficiencies and I think many of the unintended effects of our current medical malpractice system.

I am very grateful that your committee is beginning this inquiry, because it seems to me that in the aftermath of the failure to adopt health care reform in the last session—and one need not go over the causes for that failure—one of the lessons clearly was that we should pick out some pieces of the problem, that is, the problem that people are facing out there, and try to address them in this session of Congress. And I think that medical malpractice reform is a key element of that because the medical malpractice crisis is a stealth contributor to what makes people angriest about our health care system today, which is to say its costs are inflated, and it is often not universally available.

The medical malpractice system that we have now, as Senator McConnell has indicated, is a cause of both of those effects—higher

costs than are necessary and less widely available care than we should have.

Madam Chair, I am going to focus very briefly in my testimony—and I have a longer written statement which I will introduce for the record—on Title I, Subtitle B of the bill, which incorporates legislation I introduced earlier this year with Senator McConnell and others, and that is S. 303, the Biomaterials Access Assurance Act of 1995.

This is a little bit like those television sets that have the picture within the picture; this is an intense part of the broader problem of malpractice breakdown and product liability breakdown and the effect it has on people.

Subtitle B of the bill seeks to avert an imminent shortage of raw materials for use in medical device implants. Our current liability system actually threatens the availability of raw materials for us in what are quite literally, as you will hear today, lifesaving medical devices.

Last year, in that golden bygone era when I was actually chairman of the subcommittee on regulation and Government information, I held a hearing to examine this problem. Witness after witness pointed out that the current legal liability system makes it too easy to bring lawsuits against raw material suppliers and too expensive for those suppliers to defend themselves when they are not at fault. Because of this, many suppliers have actually decided that the costs of defending these lawsuits are just, plain too high to justify selling raw materials to the makers of implantable medical devices.

In short, for those suppliers, it just is not worth it.

Let me provide an example. A company named Vitek manufactured an estimated 26,000 jaw implants, using about 5 cents worth of DuPont Teflon in each device—a nickel's worth of Teflon. The device was developed, designed and marketed by Vitek, which was not at all connected to DuPont; DuPont was simply a raw material supplier. When those implants failed, Vitek declared bankruptcy, and the patients sued DuPont.

Now, DuPont has won virtually all of those cases, because it was not guilty of negligence. One of the last of the cases was actually dismissed earlier this month. But the cost of litigation has been staggering.

One study that I have seen says that DuPont has spent approximately $8 million per year over the last 6 years to defend these lawsuits, all of them originating from a nickel's worth of Teflon in each of these jaw implants.

Faced with this overwhelming liability, DuPont decided 2 years ago to stop selling its products to manufacturers of permanently implanted medical devices. DuPont has subsequently, through its own voluntary action, allowed manufacturers to purchase up to 3 years more worth of raw materials, but the clock is ticking.

There is more at stake here, obviously, than just protecting suppliers from liability. What is at stake is the health of millions of Americans who depend on medical devices for their everyday survival. What is at stake is the health of children like Tom Reilly from Houston, TX, who testified at our hearing last year. Tom suffers from hydrocephalus, a condition in which fluid accumulates

around the brain. A special shunt with rubberized material in it, supplied by a raw materials company, enables him to survive.

What is at stake is the well-being of Luke Lindenthal who, as you will hear today, has benefited tremendously from a medical device called a neuro-cybernetic prosthesis, or NCP. The device contains silicone, and suppliers of the material have similarly expressed fear about their exposure to liability. Thus, the raw materials needed to manufacture these devices may soon become unavailable.

Subtitle B of the bill before you today, I am confident will help ensure the continued availability of this and other effective medical implants. The scope of the problem affects young and old alike. Take a pacemaker. As detailed in my written testimony, raw materials for pacemakers and heart valves are at risk of serious shortages, imminent shortages as well. Now, we simply cannot allow the over 7 million people who owe their health, their lives, in fact, in many cases, to these and other medical devices, to become casualties of an outmoded legal liability system.

Subtitle B of the bill before you would establish clear national rules to govern lawsuits against suppliers of raw materials and component parts for permanently implantable medical devices. Under the bill, a supplier of raw materials or component parts can only be sued if the materials they supply do not meet contractual specifications or if they can properly—that is, the supplier—can properly be classified as a manufacturer or seller of the whole product.

The supplier cannot be sued for deficiencies in the design of the final device, the testing of the device, or for inadequate warnings with respect to that device, which are clearly the responsibility of the manufacturer.

So Madam Chair, in closing, I would say that enactment of this bill will improve our malpractice system, both for patients and providers, and will help ensure that America's patients continue to have access to the best lifesaving medical care and medical devices in the world.

Thank you.

[The prepared statement of Senator Lieberman follows:]

PREPARED STATEMENT OF SENATOR LIEBERMAN

Madam Chair, members of the committee, thank you for the opportunity to testify before your committee today on S. 454, the Liability Reform and Quality Assurance Act of 1995. I was pleased to join Senator McConnell and the Chair of this committee as a cosponsor of the bill. The bill is designed to reduce the inefficiencies and mitigate the unintended effects of our malpractice system.

Our present system for compensating patients who have been injured by medical malpractice is ineffective, inefficient, and in many respects, unfair. The system promotes the overuse of medical tests and procedures, and diverts too much money away from victims. The Rand Corporation has estimated that injured patients receive only 43 percent of spending on medical malpractice and medical product litigation. And victims often receive their awards after many years of delay.

Our medical malpractice system is a stealth contributor to the high cost of health care. The American Medical Association reports that in the 1980's, liability insurance premiums grew faster that other physician practice expenses. The cost of liability insurance has been estimated at $9 billion in 1992.

So called "defensive medicine" costs are an even greater concern. The Office of Technology Assessment has found that as many as 80 percent of diagnostic procedures are ordered primarily because of doctors' concerns about liability. These defensive practices, although difficult to measure, present a hidden but significant burden

on our health care system. The health care consulting firm, Lewin-VHI, has estimated that physician and hospital charges for defensive medicine were as high as $25 billion in 1991.

Taxpayers and health care consumers bear the financial burden of these excessive costs. Liability insurance and defensive medicine premiums drive up the cost of Medicare and Medicaid and of private health care premiums. Further, in some specialties, such as obstetrics, where malpractice premiums have skyrocketed, malpractice liability may be reducing access to quality health care. The American College of Obstetricians and Gynecologists reports that malpractice costs for ob/gyns increased 350 percent between 1982 and 1988, and that by 1988, 41 percent of those ob/gyns surveyed indicated chat they had made changes in their practice patterns, such as ceasing to serve high-risk patients, because of malpractice concerns.

The bill we are discussing today will begin to address these inefficiencies and perverse effects of our malpractice system by directing a greater portion of malpractice awards to victims, by discouraging frivolous law suits, and by enhancing quality assurance programs. Key provisions of this malpractice reform bill include:

—Establishing a uniform statute of limitations, two years from the date the injury was discovered.

—Allowing periodic payments for awards greater than $100,000.

—Applying several, not joint and several, liability for noneconomic and punitive damages.

—Limiting attorneys' contingency fees to 33⅓ percent of the first $150,000 of an award and 25 percent of any amount above $150,000.

—Establishing a clear and convincing evidence standard of proof of wrongdoing for doctors delivering a baby who had not previously treated the pregnant woman.

—Requiring States to establish mandatory alternative dispute resolution for medical malpractice cases.

—Strengthening the standard for awarding punitive damages and establishing State health care quality assurance programs funded with 50 percent of punitive damage awards.

—Requiring providers and insurers to participate in risk management programs every 3 years to better detect and prevent practices which may result in patient injury.

In addition, Title I, Subtitle B of the bill incorporates legislation I introduced earlier this year with Senator McConnell and others—S. 303, the Biomaterials Access Assurance Act of 1995. Subtitle B seeks to avert an imminent shortage of raw materials for use in medical devices implants. Our current liability system threatens the availability of raw materials for use in life-saving medical devices.

Last year, as Chairman of the Subcommittee on Regulation and Government Information, I held a hearing to examine this problem. Witness after witness pointed out that the current legal system makes it too easy to bring lawsuits against raw materials suppliers and too expensive for those suppliers to defend themselves—even when they were not at fault and end up winning. Because of this, many suppliers have decided that the costs of defending these lawsuits are just too high to justify selling raw materials to the makers of implantable medical devices. In short, for those suppliers, it just isn't worth it.

A recent study by Aronoff Associates paints a clear, but dismal, picture. That study surveyed the markets for polyester yarn, resins such as DuPont's Teflon, and polyacetal resin such as DuPont's Delrin. The study showed that sales of these raw materials for use in manufacturing implantable medical devices was just a tiny percentage (0.006 percent) of the overall market—$606,000 out of total sales of over $11 billion.

In return for that extra $606,000 in total annual sales, however, that raw material supplier, like others, faced potentially huge liability-related costs, even if they never lose a lawsuit. To take one example, a company named Vitek manufactured an estimated 26,000 jaw implants using about 5 cents worth of DuPont Teflon in each device. The device was developed, designed and marketed by Vitek, which was not related to DuPont. When those implants failed, Vitek declared bankruptcy, its founder fled to Switzerland and the patients sued DuPont. DuPont has won virtually all these cases—one of the last cases was dismissed earlier this month—but the cost has been staggering. The study estimated that DuPont alone has spent at least $8 million per year over 6 years to defend these suits.

To put this into perspective, DuPont's estimated legal expenses in these cases for just one year would buy over a 13-year supply of DuPont's Dacron polyester, Teflon and Delrin for all U.S. makers of implantable medical devices, not just makers of jaw implants.

Faced with this overwhelming liability, DuPont decided 2 years ago to stop selling its products to manufacturers of permanently implanted medical devices. DuPont

has subsequently allowed manufacturers to purchase up to 3 more years worth of raw materials.

One supplier's decision alone might not be troublesome except that there is no reason to believe that the economics will be different for other suppliers around the world. One of the witnesses at the hearing testified that she had already contacted 15 alternate suppliers of polyester yarn worldwide. All were interested in selling her raw materials—except for use in products made and used in the United States. By itself, this is a powerful statement about the nature of our American product liability laws, and makes a powerful case for reform.

There's more at stake however, here than just protecting suppliers from liability. It's more than just making those raw materials available to the manufacturers of medical devices. What's at stake is the health of millions of Americans who depend on medical devices for their every day survival.

What's at stake is the health of children like Thomas Reilly from Houston, TX, who suffers from hydrocephalus, a condition in which fluid accumulates around the brain. A special shunt enables him to survive. But continued production of that shunt is in doubt because the raw materials' suppliers are concerned about the potential lawsuit costs. At. our hearing last year, Thomas' father, Mark Reilly, pleaded for Congress to move forward quickly to assure that the supply of those shunts will continue.

What's at stake is the health of adults like Peggy Phillips of Falls Church, VA, whose heart had twice stopped beating because of fibrillation. Today, she lives an active, normal life because she has an implanted automatic defibrillator. Again, critical components of the defibrillator may no longer be available because of potential product liability costs. Ms. Phillips urges Congress to move swiftly to enact legislation protecting raw materials and component part suppliers from product liability.

What's at stake is the well-being of Luke Lindenthal who, as he will tell you today, has benefited tremendously from a medical device called a neuro-cybernetic prosthesis, or NCP. That device has helped greatly reduce Luke's epileptic seizures. But the device contains Silicone, and suppliers of this material have expressed concern about their exposure to liability. Thus, the raw materials needed to manufacture NCPs may become unavailable. Subtitle B of the bill before you today will help ensure the continued availability of this and other effective medical implants.

The scope of this problem affects young and old alike. Pacemakers, for example, are installed in patients whose hearts no longer generate enough of an electrical pulse to get the heart to beat. To keep the heart beating, a pacemaker is connected to the heart with wires. These wires have silicone rubber insulation. Unfortunately, the suppliers of the rubber have begun to withdraw from the market. With this pacemaker, thousands of Americans can live productive and healthy lives for decades.

Heart valves provide another example. Around the edge of a heart valve is a sleeve of polyester fabric. This fabric is what the surgeon sews through when he or she installs this valve. Without that sleeve, it would be difficult, if not impossible, to install the valve. Without that valve, patients die prematurely.

In short, this developing product liability crisis will have widespread and serious effects. We cannot simply allow the over seven million people who owe their health to medical devices to become casualties of an outmoded legal liability system. Because product liability litigation costs make the economics of supplying raw materials to the implantable medical device makers very unfavorable, it is imperative that we act now. We cannot rationally expect raw materials suppliers to continue to serve the medical device market out of the goodness of their hearts, notwithstanding the liability-related costs. We need to reform our product liability laws, to give raw material suppliers some assurance that unless there is real evidence that they were responsible for putting a defective device on the market, they cannot be sued simply in the hope that their deep pockets will fund legal settlements.

I have long believed that liability reform could be both pro-consumer and pro-business. I believe the testimony we heard on this subject last year proved this once again. When fear of liability suits and litigation costs drives valuable, life-saving products off the market because their makers cannot get raw materials, consumers are the ones to suffer. When one company must spend millions just to defend itself in lawsuits over a product it did not even design or make—for which it simply provided a raw material worth 5 cents—it is the consumer that suffers the most. The hearing last year dramatically illustrated that efforts to increase compensation for the injured can sometimes come at an unacceptably high cost.

Subtitle B of the Liability Reform and Quality Assurance Act will establish clear national rules to govern suits against suppliers of raw materials and component parts for permanently implantable medical devices. Under the bill a supplier of raw materials or component parts can only be sued if the materials they supplied do not

meet contractual specifications, or can properly be classified as a manufacturer or seller of the whole product. They cannot, however, be sued for deficiencies in the design of the final device, the testing of that device, or for inadequate warnings with respect to that device. The enactment of this bill would help ensure that America's patients continue to have access to the best life-saving medical devices in the world. We must act now, however.

Madame Chair, many of the reform ideas in the Liability Reform and Quality Assurance Act were proposed or cosponsored by Democrats and Republicans in the last Congress as part of comprehensive health care reform bills. A number of these ideas were embraced last year by a group of us participating in the bipartisan Senate "Mainstream Coalition. " But we had little chance to debate these issues in the last Congress. I am optimistic that we will have the opportunity in this Congress to pass a bipartisan medical malpractice reform bill. I thank the committee for their consideration of the legislation and I look forward to working with members of the committee to improve our medical malpractice system.

The CHAIRMAN. Thank you very much, Senator Lieberman.

I know Senator McConnell has to leave to chair a hearing at 10 o'clock. Senator Lieberman, can you stay, or do you have to leave at 10 as well?

Senator LIEBERMAN. I can if you would like, certainly.

The CHAIRMAN. Just for a few minutes. I think there are some questions, and as you say, we can submit questions in writing.

Senator MCCONNELL. Yes. I am very anxious, Senator Kassebaum, to answer whatever questions are asked.

The CHAIRMAN. Thank you very much. Thank you for coming.

If you do not mind staying for just a minute, Senator Lieberman.

Senator LIEBERMAN. Not at all.

The CHAIRMAN. I would like to turn to Senator Jeffords.

Senator JEFFORDS. Thank you, Madam Chair, and Senator McConnell, I will be joining you momentarily in your hearing.

First, Senator Lieberman, I am so pleased to see that you have introduced this bill. I think it is a tremendous step forward in coming up with something which can be reasonable and can be enacted.

I believe your bill is broader than the most typical malpractice bills by specifically noting the breadth of whom health care liability actions can be against. On the top of page 6 of your bill, it reads as follows: "against a health care payor, health maintenance organization, insurance company, or other individual, organization or entity that provides payment for health care benefits in which the claimant alleges that the injury was caused by the payments for or failure to make payment for health care benefits." Then it has the proviso clause, "except to the extent such actions are subject to the Employee Retirement Income Security Act."

Through my work with the committee last year and with Senator Dodd as a cosponsor, we examined the problems in this area. What I am concerned about is that the exemption there of ERISA plans—and when you mention the word ERISA, everybody gets petrified and terrified, and you cannot touch it——

Senator LIEBERMAN. That is right.

Senator Jeffords [continuing]. But two-thirds of people are covered under ERISA plans, so don't you think that all of these plans should operate under the same rules, and why did you decide to exclude basically most of the private market in that respect?

Senator LIEBERMAN. I completely agree with you that we need to expand the remedies available to consumers in ERISA plans. As you know, it was my privilege to work with you in the so-called

Mainstream Coalition last year as part of the debate to put together what I thought was a pretty good proposal about creating more remedies for patients who are denied coverage by either insurers and/or ERISA plans. I think you and I remember laughing to each other that we thought we had a pretty good proposal because everybody did not like it, although I think patient groups felt it was a pretty good step forward.

The decision that Senator McConnell and I made on this one, frankly, Senator Jeffords, was tactical and not a matter of policy, which is to say that, learning from our experience last year, we were concerned that if we included the ERISA plans in this provision, it might well create another series of opponents to the overall bill which would make it difficult to pass.

But I must say that on the matter of substance, I agree with you, and if you and the members of the committee feel that we can work together on this to add ERISA plans and not jeopardize the underlying bill, I would be happy to do so.

This year, as you know, you and I and several other members of the Senate have asked the GAO to examine the effects of ERISA on the insurance market and to look at the differences in regulatory requirements that ERISA and nonERISA plans face. And it may well be that while you are considering this bill in this committee that that report would be forthcoming and would give us a basis for proceeding, but as I say, bottom line, the decision was tactical and not substantive. I would be glad to work with you to see if we can make this part of the bill.

Senator JEFFORDS. Thank you. I appreciate those comments. I sort of have a political death wish on these kinds of issues, where I like to go after those things which everybody gets mad at.

Senator LIEBERMAN. I have noticed. What troubles me is that you have brought me along on a few of those issues. [Laughter.]

Senator JEFFORDS. I am hoping that with the work we are doing on ERISA reform that we can get people to understand the necessity for treating all of these things together.

Senator LIEBERMAN. Absolutely.

Senator JEFFORDS. I commend you again for your work on this bill and for what you did on the mainstream committee, and I know there are a number of us who are going to try to work together to find some of these answers. So thank you very much for your help.

Senator LIEBERMAN. Thank you.

The CHAIRMAN. Thank you very much. Now, I know you have a 10 o'clock hearing, too.

Senator LIEBERMAN. Yes, but as befits my party in this session, I have less responsibility at the 10 o'clock hearing than Senator McConnell does, so if there are any questions, I can stay.

The CHAIRMAN. Well, then, Senator Kennedy, I will call on you.

Senator KENNEDY. I know the feeling. [Laughter.]

Thank you very much, Madam Chairman. I welcome Senator McConnell and Senator Lieberman, and I know they have given a great deal of attention to this issue.

As the Senator probably knows, during the course of our health reform discussions last year, our committee gave some attention to malpractice, and there was a good deal of discussion about pre-

empting State laws on this. As a result of some very interesting and engaging exchanges, it was ultimately resolved that there would be no preemption one way or the other. President Clinton's initial proposal included preemption, and we debated whether we have to have preemption, since the kinds of injuries that are taking place in the State are matters that the State knows best about. This is different from product liability reform because you are talking there about products that travel interstate. With malpractice, the States have been making their own independent judgments, and this should not be an area where we are going to have Federal preemption.

And as a result of a good deal of exchange last year, that is where we came out; no preemption, with the exception of where the States had taken no action at all.

So it is interesting to me that one of the first orders of business when we come back here is Federal preemption of State law in these areas. I know the matter that you spoke to with regard to bio-materials is a complex issue and one that I think we ought to give attention to. We have been interested in the issue of medical device legislation and protection. So I hope we can address that concern.

But it is interesting that when Congress comes back to the issue of health care, the first thing we do is extend the tax deduction for small businesses, which will cost $8 billion over the next 10 years, and we do nothing for any of the workers in those areas. That was voice-voted on the floor of the U.S. Senate, so that we could quickly take care of a number of small businesses. Even though those small businesses employ 400,00 workers, we did not give those workers a break at all. We voice vote that, and then the next thing we do is help out negligent doctors with malpractice reform that preempts some States' activities. It is interesting where the priorities are in this Congress.

And this is against a background where we have seen malpractice premiums declining, malpractice suits declining, and malpractice insurance profitability has soared.

The March 24, 1994, Business Insurance Week states: "Despite the rapidly changing health care delivery system, the price of medical malpractice and professional liability coverage for a health care organization remains stable, and capacity is plentiful. Insurers view malpractice hospital and professional liability and related coverage as profitable lines these days, brokers say. In fact, some insurers are looking to increase their malpractice accounts in an attempt to offset meager underwriting results in the commercial property market." It goes on: "It seems like every month, a new insurer wants to underwrite medical liability coverage for health care organizations. As long as companies are making profits that exceed the average property casualty profit line, they will want to underwrite this coverage."

Profits are going right through the roof in this area. So when we are seeing profits going through the roof, we are talking about an area which States have been moving on, and we are talking most importantly about what happens to people, their real lives, their health, their well-being, the well-being of their children and their parents, I think we have to be exceedingly cautious.

I understand the drive to try to move this along in terms of the product liability issue, although as I mentioned before, I have some concerns about that, but I think that this is a different issue. I may be in the minority in that view, but I do think that we ought to be cautious.

Let me ask you, Senator Lieberman, as a former attorney general, you know well that the tort law has traditionally been a State prerogative, and there are some reasonable arguments in favor of Federal intervention in the product liability law where the goods travel in interstate commerce. When medical negligence occurs within a State, the Federal law in this context seems not to facilitate commerce, but to tip the scales in favor of the malpractice defendants over the malpractice plaintiffs.

Do you have any concerns about preempting a body of law traditionally entrusted to the States, and are you comfortable that S. 454 adequately protects the role of the State tort law in the Federal system?

Senator LIEBERMAN. I am, and I appreciate your question. Let me say first, generally, Senator Kennedy, that the extent to which this bill would create a national floor for medical malpractice cases, as in a way, you suggested in your opening remarks, supports your basic position that the health care crisis is a national problem and does require national solutions.

The fact is that the current tort liability system and tort system has gone astray, and this area and product liability and generally, in civil liability, is costing the public much more than it should, and is part of a crisis of confidence in the general system of justice in our country, both criminal and civil, because people think the system is being gamed. It is one thing to have injured parties, for instance, get compensation, and quite another for the lawyers' fees, as they are proven to be in these cases, taking an extremely high percentage of the awards.

So I would say that the aim here is to create a national floor to allow States to go beyond this if necessary, and to the extent possible to leave to the States the determination of liability of negligence. But most of what this bill will do to reform the system is to go to the question of damages, which is the area—particularly punitive damages and noneconomic damages—to go to the question of whether an attorney can essentially in behalf of a client play a kind of—I hate to call it "legal terrorism"; that is too strong—but to bully the system for fear of what a jury will do in awarding punitive damages into awarding more than negligence would otherwise require simply to avoid the unknown of a court case.

And I do think that the bill that we have put in here clearly protects the right of injured people, plaintiffs, to recover not only for their out-of-pocket costs, but for the noneconomic, so-called pain and suffering damages, which are not capped in this proposal before you and yet creates, I guess I would say, some parameters that will make the system more reasonable and less costly.

The last numbers that I saw said that between the cost of insurance premiums and the OTA's estimate of defensive medicine practiced for fear of liability, we are putting out—that is, all of us who are health insurance premium payers—are putting out $35 billion

a year. Now, if we can cut that down and the cost of health care, we will have made a substantial step forward.

Senator KENNEDY. Thank you.

Madam Chairman, I have one other question, since I was particularly interested in the obstetrics issue. Could I just ask about the change in obstetrics liability?

The CHAIRMAN. Briefly, briefly.

Senator LIEBERMAN. I will give a very brief answer if it is acceptable, Madam Chairman, and I would be glad to talk with you more about it, Senator Kennedy.

I think the aim here looked to the best of all worlds, because the obstetricians have suffered probably the greatest increase in premiums costs, or at least, let me say, very significant, and it has had the effect of convincing some people that I know to leave the delivery of babies.

But the aim here in limiting it to those who have not treated the mother during pregnancy, frankly, was to try not to take on the whole problem, but to deal with an area that we consider to be most critical, which is pregnant mothers in rural areas, that is, areas where they may not have day-to-day contact with an obstetrician, and they may go to some central clinic or hospital to have the baby delivered. So at least, we wanted to try in that way to increase the pool of available obstetricians to deliver babies.

I would be glad to talk with you about that.

Senator KENNEDY. Thank you.

The CHAIRMAN. Senator Coats wanted to ask a brief question, too, if you could stay.

Senator LIEBERMAN. Sure.

Senator COATS. I had a follow-up on that obstetrics question, and Paul, you would be interested in this. Down in Evansville, IN, there is an obstetrician who moved from southern Illinois to Indiana for his practice. He was the only obstetrician left in a 10-county area in southeastern Illinois, and he was driven out of business in Illinois due to the liability.

He brought his case to the former Governor of Illinois and asked him what he ought to do about it, and the Governor told him to switch to dermatology. Instead, he moved to Indiana.

Now, there are many people from Illinois who come over—we appreciate the business, but they have to drive an awful long way for obstetrics treatment—and that is one of the concerns I think that they are trying to address here.

Senator LIEBERMAN. That is right.

Senator COATS. State laws are just all over the place relative to this, and I think one of the things that Senator Lieberman is trying to accomplish with his bill is to provide for some uniformity because, as he said, it is a national problem.

My question, Senator Lieberman, is a lot of information that comes in would indicate that overall damage caps are the most effective way of providing the types of tort reform. In fact, a study by The Hudson Institute indicated, and I quote: "Damage caps are the most effective tort reform and generally have the strongest impact on damages awarded of any way that was tested."

My understanding is that your bill does not place an overall cap on total damage awards. Am I correct in that?

Senator LIEBERMAN. That is correct. The bill places a cap on punitive damages—let me go back. Your first statement is absolutely right. All the studies that I have seen say that the two most successful changes or reforms at the State level that have actually lowered costs in the system have been the collateral source provisions that we talked about, to count payment from other sources, and the cap on damages.

We think that the most egregious problem here comes from unlimited punitive damages. This bill does cap those. Again, I think Senator McConnell and I, understanding the difficulty of passing any kind of tort reform in Congress, looking back over the years, wanted not to overreach, although I think both of us individually would certainly be open to a cap on the so-called noneconomic or pain and suffering damages. But I think that that would probably make it just about impossible to pass the bill.

My estimates may be too pessimistic, but again, that is why.

Senator COATS. Well, I regret that for political reasons, we end up under-reaching instead of at least perhaps finding some appropriate equilibrium. I would hope that you would look at the model that Indiana has provided now for 20 years in terms of reasonable limitations on medical liability. The interesting fact is that Indiana physicians pay very substantially less, but the patients, those complainants receiving critical injuries receive more than neighboring States in their awards. The difference is the money goes to the patient instead of the attorney.

Senator LIEBERMAN. That is a very good point. The general tort system we have now too often overcompensates those who are less injured and undercompensates those who are more injured.

One thing I would add about pain and suffering, noneconomic damages, is that we have removed the rule of joint and several liability in this bill for pain and suffering and created only several liability, which is to say, as you know, that defendants would be liable only for the amount of their responsibility. In other words, as you know, in the current system, even if you are found to be 10 percent liable for the injury, if you happen to be a deep pocket, you can be forced to pay 100 percent. And on the pain and suffering, because of the way in which the concept can be used to game the system, we have at least removed the rule of joint and several liability and made it several, so that will have some inhibiting effect.

Senator COATS. Thank you very much.

Senator SIMON. Could I impose upon my colleague?

The CHAIRMAN. I would leave it up to Senator Lieberman.

Senator LIEBERMAN. It is okay with me if it is okay with you.

The CHAIRMAN. All right. Just a few minutes.

Senator SIMON. First I want to say, Madam Chair, that I have noticed since you have become chairman, we get little pieces of candy; you are a much better chairman than Ted Kennedy ever was, I want you to know. [Laughter.]

Senator KENNEDY. I think I ate all the candy myself. [Laughter.]

The CHAIRMAN. It is my staff that has provided that, but thank you.

Senator SIMON. The Office of Technology Assessment in a report says that "Medical malpractice insurance premium increases were not associated with physician withdrawal from obstetrics practice

for either ob-gyns or FPs." To my colleague from Indiana, it is very interesting that the American Hospital Association says that costs per day in a hospital in Indianapolis are higher than they are in the city of Chicago. Now, I am not saying your law or ours is a reason for that.

Senator COATS. Wait a minute—I have a chart here. [Laughter.]

Senator KENNEDY. Please leave Boston out.

Senator SIMON. I do believe that some sensible reform is in order, and I think the limitation on lawyers' fees is a move in that direction. I think alternative dispute resolution—while you go further than the health bill that we reported out of our committee last year—I think some movement in that direction is in order.

I would make one other point. The Chicago Sun Times had a story about our licensing board, the disciplinary board, in Illinois, frankly just not being firm with doctors who have loose practices. And I do not think there is any question that that is one of the reasons for the problems that we face in this field.

Then, finally, when you put a cap on punitive damages, I think of the fellow who, 10 days ago in a Tampa hospital had the wrong leg amputated. Now, when you remove the wrong leg, there might not be a lot of pain and suffering, but if Joe Lieberman or Paul Simon had a leg amputated wrongfully, I do not think we would be in favor of a $250,000 limitation on punitive damages.

So when you start looking at these specific cases, I think we have to go slowly. I would just be interested in your reaction.

Senator LIEBERMAN. Very briefly, Madam Chair, actually, in that case, a tragic case, my guess is that there will be an enormous award for pain and suffering as part of the negligent removal of that leg, just because of the way in which pain and suffering is calculated. Punitive damages we have at $250,000, or three times the out-of-pocket cost, the so-called economic damages.

We will undoubtedly end up debating this at length, but my feeling is that this is the part of the system that has most been twisted to be an element in what amounts to a kind of economic bargaining more than a real effect on the system. And the truth is that the doctor who committed that incredibly negligent act that you have described, first of all will suffer professional embarrassment, public embarrassment, but also will end up seeing himself paying an enormous pain and suffering award.

I would say finally that one of the things I am proudest about in this bill is Title II, which is the protection of patient health and safety. It authorizes each State to create a fund which will be supported by transferring 50 percent of all punitive damage awards to that fund, and the purpose is for licensing and certifying health professionals and funding programs to reduce malpractice and police the system better, including the opening up of a National Practitioner Data Bank so that patients will have more accessibility to the names of doctors who are negligent, who have tended to move from State to State.

So I look forward to working with you, Senator Simon, Madam Chairman. This is obviously a controversial, very personal area, but it is just one that cries out for reform in the public interest, and I hope we can work together toward that end. And I again thank you for your kindness.

Senator SIMON. Thank you, Senator Lieberman.

The CHAIRMAN. And we really very much appreciate your staying to answer some of the questions. It has been very helpful. Thanks so much, Senator Lieberman.

Senator LIEBERMAN. Thank you.

The CHAIRMAN. We are ready now for the second panel, and we would ask Luke Lindenthal and his family to come forward.

It is a very special pleasure to welcome as our second panel Luke Lindenthal of Mercer County, NJ, who is here with his mother, Lynne Lindenthal, at the witness table, and his father, who is accompanying Luke as well.

Luke has an implanted experimental medical device that controls his chronic epileptic seizures. Lynne Lindenthal is a registered nurse, which obviously helps in an understanding of all that takes place in the medical field.

I know that you as a family feel very strongly about this legislation, and we are pleased that you have made the effort to come from New Jersey to join us today.

Luke, it is a pleasure to welcome you. We look forward to any comments you wish to make.

STATEMENTS OF LYNNE AND LUKE LINDENTHAL, MERCER COUNTY, NJ

Mr. LINDENTHAL. The pleasure is all mine.

The CHAIRMAN. Thank you. If you have some comments and a statement, we would be happy to hear that now.

Mrs. LINDENTHAL. I think he wants me to go first.

The CHAIRMAN. All right. Mrs. Lindenthal, please.

Mrs. LINDENTHAL. Good morning. My name is Lynne Lindenthal. I am a critical care nurse by profession, and Luke's mom.

I am honored to be here today to speak with you and share with you our experiences with medical technology and how it has positively impacted our lives. This is why Senator McConnell's and Senator Lieberman's bill and its passage is so important to us and crucial to the 7.4 million other Americans who are dependent on implants.

Our child Luke was born on August 5, 1977—a normal, healthy delivery. He weighed in at 8 pounds, 4 ounces and was 22 inches long.

Luke's infancy and childhood were filled with the normal milestones until the age of 2½. At the age of 2½ 10 days after his fourth DTP immunization, Luke was diagnosed with epilepsy, and we watched our normal, healthy child deteriorate before our eyes.

Luke began having as many as 80 to 120 seizures daily. We know this because we kept daily seizure logs. We tried all of the anti-epileptic medications—dilantin, phenobarbital, tegretol, mysoline, diamox, paraldehyde, valium, valproic acid, and klonopin.

By the age of 3½ Luke could no longer hold a pencil or stack blocks without having attention tremors. He could no longer speak in sentences and had virtually no attention span. Luke's seizure activity was diffuse—meaning it was in all areas of his brain.

Luke has intractable epilepsy. We were told that unless we could find a way to control the frequent seizure activity, Luke would ei-

ther be dead or in a permanent vegetative State within a year's time.

Fortunately, a medication combination was found that slowed the seizure activity down—for a while, anyway. However, when the seizure activity resumed, it was with a vengeance and wrath like we never would have dreamed possible—not in our wildest nightmares.

Luke would go into status epilepticus at least once a week. Status epilepticus would last for 3 to 4 hours and included cardiac and respiratory arrest. It was at this time that we taught Luke's brothers and sisters CPR. It became a way of life for all of us, especially Luke.

Our lives revolved around keeping Luke alive.

Luke has no memory of those years—not birthdays, not Christmases, not happy times, not sad times. Time did not exist in his memory. There was no room for anything but the tumultuous seizures.

Fortunately in this country, medical technology has been allowed to prosper. We were made aware of the NCP, or the neuro-cybernetic prosthesis, and the benefits that some patients with intractable epilepsy were experiencing. Luke became the first child in the world to have an NCP implanted for seizure control. We knew that there was a chance that the device, like all of the medicines before it, would not work. But there was also a chance that the device would work. Either way, it was a chance at a life that had ceased to hold any type of normalcy or quality for Luke.

Fortunately, the NCP worked for Luke. The results were immediately obvious—from improved fine motor skills to speech formation to math skills and, most importantly, a phenomenal decrease in his seizure activity—from 120 seizures daily to none. He has now not even had a small seizure since November. So now we can start working on that driver's license.

There are 7.4 million Americans who rely on such medical devices. It is important to us that this type of advancement in medical technology be allowed to continue to flourish. It is evident to us, however, that our legal system is no longer protecting our rights, but jeopardizing Luke's life. We must all combine our efforts to prevent a medical crisis that could bring utter desolation and destruction to many lives.

We were fortunate. Luke was given that all-important opportunity to be a part of the trial studies of the NCP. The technology was available, the raw materials were available, and the implant became a reality. The smaller medical technology companies provide a major source of innovation in the medical technology field. These companies may have to use their resources from product research and development and FDA regulatory proceedings to search for and validate any substitute materials that may be found.

I never want to watch Luke go through another status epilepticus, respiratory arrest or cardiac arrest again. I do not want to watch my child die, knowing that if only the raw materials were available, he would still be with us; that if only this bill had been passed, he would be with us.

Please help Luke to live on the cutting edge of technology where the sun is bright, and life is full of dreams. Do not force him to live in a dark cave full of pain.

Thank you.

The CHAIRMAN. Thank you very much, Mrs. Lindenthal.

Luke, do you have some comments you would like to make?

Mr. LINDENTHAL. Yes, I only have one. I want to know why the people who make the silicone are not going to be making them anymore.

The CHAIRMAN. The people who make the silicone that is used in your device.

Mr. LINDENTHAL. For the device, yes. I want to know why they are not going to be making them anymore.

The CHAIRMAN. Well, that is a good question, and that is what we are trying to help work through with this hearing and debate that very question. And I am sure that if you are getting ready to take your driver's license test, that is going to be a very important milestone as well, so we wish you well in that.

Let me ask a few questions, perhaps—is that all that you would like to comment on, Luke, as your statement?

Mr. LINDENTHAL. Yes.

Mrs. LINDENTHAL. No. You have a speech, Luke.

He has a speech, too. Go ahead.

Mr. LINDENTHAL. Good morning, ladies and gentlemen. I am very pleased to be able to be here to speak with you today.

My name is Luke Lindenthal, and I have been challenged in life with epilepsy. I was the first child in the world to have an implant for seizure control. This implant has given me back my life, my memory, and hope for tomorrow.

I can remember small parts of my life before receiving my implant. It was very confusing to watch my younger brother and sister pass me in their classes at school and in their abilities to deal with life's challenges. My sister Johanna taught me to read.

Since I have had my implant, life has become much more clear. My life is going full force. All of the things I was told I would never be able to do, I am learning to do. I ride my skateboard and my bike, I run sometimes a mile a day, I swim and dive, and I learned how to snow ski this past winter.

What makes me worry today is a feeling that I shall become an Algernon. In the book, "Charly," a man was given the chance to become a complete person. This is the man that I have become. The thing that worries me is the fact that due to other people's greed for financial opportunity, I may come to the same end as Charly—except for the fact that Charly does not die.

We must have some rules that protect those who need from those who greed. If we continue to let people make their living by finding holes in the law that is made to protect the people of this country, then we as a people not only let those of us down who dream of a normal life, but those who have the dream to help those of us in need. The message is one that says: You may be willing, but is your concern great enough that you can shoulder the threat of being sued?

It is important to me that this bill and others like it be considered so that I and others like me have the same chance at life that you do.

Thank you for your interest. My life is in your hands.

The CHAIRMAN. Thank you, Luke, very much.

If I may just ask a few questions of you and of your mother—you are 17 now, Luke, is that right?

Mr. LINDENTHAL. That is correct.

The CHAIRMAN. And do you have any idea how long it will be before you have to consider replacing the NCP device?

Mrs. LINDENTHAL. We actually have had it replaced three times—once because the battery wore out. Depending upon the amount of milli-amp voltage that is used, that determines how long the battery will last. The battery died, and we needed a replacement.

We did get to see for a few days what life was like before, and it was not pleasant to see again.

Luke was ice-skating with his brothers and sisters one time, and fell. He was 4 feet, 6 inches tall when he first got his implant, and he is now 5-9, 5-10. So the wire was strained, and when he fell, it snapped the wire, so he had to have a replacement done.

They were certainly replacements that not only we but Luke were willing to make. His comment when he was in the doctor's office was, "Let's go; let's do it now."

The CHAIRMAN. Is that easily done?

Mrs. LINDENTHAL. The battery replacement is very easily done because the device sits in the left anterior chest—if you know anybody who has a pacemaker, it sits right in the same area and is approximately the same size——

Mr. LINDENTHAL. And the wires go up, around the vagus nerve, right around here, and are connected to the computer.

Every 5 minutes when I was giving my speech, I could hear the computer going off, so that means that I am getting shocks to stop the seizures.

Mrs. LINDENTHAL. It sits in a subcutaneous pocket, and it just has to be opened up, the device comes out, the old battery is taken out, and the new battery is put in.

The CHAIRMAN. Now, Luke, you mentioned the silicone. Do you have any sense, in talking with the personnel that you deal with, of how long the raw materials that are used in the implanted medical devices will be available? Is there any concern about that?

Mrs. LINDENTHAL. Yes, there is. Different companies have been able to stockpile different amounts pertaining to the companies. If you have had the opportunity to read the Arnoff report that HIMA had done, that was in 1994, and I believe it was 2 to 4 years of raw materials that had been stockpiled. I believe the company that makes Luke's device has a year's supply left.

The portions of his device that the silicone is used for—there are two electrodes that sit on the vagus nerve. If you feel your pulse in your neck, the vagus nerve runs right by there. There are two electrodes that sit on the vagus nerve. Silicone is used with those. Silicone is used with the wires that go from the computer to the electrodes, and the computer itself is coated with silicone.

The CHAIRMAN. So there is a shortage and a danger that this will not be available—and why?

Mrs. LINDENTHAL. Well, I believe Senator Lieberman spoke to that fact, that DuPont was the major manufacturer of the silicone. Silicone is one of the raw materials that is used and bought for this device, and if you cannot get hold of it, it is not going to be.

The CHAIRMAN. And the high cost of doing so; is that a concern?

Mrs. LINDENTHAL. I do not believe that they were charging a high cost. It is the fact that the lawsuits and liability are just making it not a good business venture for them.

Mr. LINDENTHAL. Excuse me, Senator. Can I ask a question?

The CHAIRMAN. Yes.

Mr. LINDENTHAL. If DuPont is getting ready to sue, then how come they have all this technology, and they do not want to share it with other people?

The CHAIRMAN. Why don't they want to share it with others?

Mr. LINDENTHAL. Yes, because if they do not, other people like me will not have the chance at life like I do; they will die without the opportunity of learning any more.

The CHAIRMAN. I would guess that as this is perfected, it will be shared. One of the things we are trying to address, of course, is helping to expand the availability of the raw material and the certainty that it would be there, largely with some assurances that liability costs will not make it prohibitive—because this would affect, I assume, pacemakers and everything, every other device where the silicone is used as a raw material.

So I think yours is persuasive testimony, first of the great value of the NCP device that you have and the absolute importance of it, and for us trying, through legislative efforts, to expand that availability and the certainty of that availability. That is what we would hope that this legislation would help to address.

Thank you very much for your thoughtful comments.

Senator Kennedy.

Senator KENNEDY. Luke, I would just like to thank you very much for being here, and thank your mom as well. It is never easy to talk about these matters and to share them even with your friends, let alone talk about them here in this committee room. But I think you should know that because you have done it, there will be others, hopefully, whose lives will be both saved and, hopefully, enhanced.

Mr. LINDENTHAL. I hope so.

Senator KENNEDY. I want to thank you very much, and I want to thank your mother. You are a very lucky young man. I know she is lucky to have you, but you are very lucky to have her and her real dedication.

Let me ask you on another item, Mrs. Lindenthal, do you have health insurance coverage?

Mrs. LINDENTHAL. Well, it is funny you mention that.

Senator KENNEDY. It is an old question around here.

Mrs. LINDENTHAL. It is a loaded question, and I am going to give you a loaded answer. We have health care insurance at this time that covers Luke 100 percent. They even include costs for his implanted device because of the huge difference of medical care beforehand and now in monetary value.

When I was working in a different State than I am now and my husband was active duty Marine Corps, we had the wonderful insurance that the hospital offered its employees. They paid 80 percent of what they deemed medically necessary for everybody in our family. However, Luke had a preexisting condition, and we always had a difficult time.

The last year before his implant, the cost that that insurance did not pay was $130,000 to keep Luke alive.

Senator KENNEDY. So that is your indebtedness at this time?

Mrs. LINDENTHAL. No, we are not indebted at this time.

Senator KENNEDY. But the bill was $130,000.

Mrs. LINDENTHAL. The medical bills for 1 year to keep Luke alive were $130,000. They are paid off at this time.

Senator KENNEDY. And you are able to continue your health care coverage at the present where you are working.

Mrs. LINDENTHAL. Yes. We have two separate HMOs, and between the two of them, they haggle it out. The medical advisors on each one of them have decided it is best to pay the costs for the implant, so that has been very good, also.

Senator KENNEDY. Are you concerned at all about keeping your health care coverage?

Mrs. LINDENTHAL. Not at this time.

Senator KENNEDY. Good. Thank you very much.

Thank you very much, Madam Chairman.

The CHAIRMAN. Thank you.

Senator DeWine.

Senator DEWINE. No questions.

The CHAIRMAN. Senator Ashcroft.

Senator ASHCROFT. Thank you, Madam Chairman.

I just want to thank you for coming and bringing us the information which I think can provide a basis for our good decisionmaking in this area.

Thank you, Luke.

The CHAIRMAN. Senator Simon.

Senator SIMON. I want to thank Mrs. Lindenthal and Luke, both of you, for coming here. I really appreciate it.

Let me follow up on the question of Senator Kennedy. Have you ever thought, Mrs. Lindenthal, what it might be like if you were one of the 41 million Americans who had no health insurance?

Mrs. LINDENTHAL. Well, yes. I think it would be fairly scary. We are all fairly fortunate that we do not get sick. We have three other children who are all healthy. But all you need is one illness when you have only a partial coverage on your insurance, and you are wiped out; you are absolutely wiped out.

My stepfather before he died had a five-vessel bypass. He had one of those insurance policies that only paid a partial amount, and when he died, it left my mother with a $250,000 medical bill.

So it is something that you always have to think about. You always have to check and make sure that you are covered because it can wipe out everything you have ever tried to save.

Senator SIMON. I thank you very, very much.

The CHAIRMAN. Senator Gorton.

Senator GORTON. No questions, Madam Chairman.

The CHAIRMAN. Thank you very much, Mrs. Lindenthal and Mr. Lindenthal, and Luke, thank you. It is not easy to come and testify here, as Senator Kennedy pointed out, but I think it helps us to understand, and when you can come and explain to us how important it is to you and how important it really is for many others, and you are speaking for them, that is of great value, so we deeply appreciate it.

Thank you.

Mr. LINDENTHAL. Thank you.

The CHAIRMAN. It is a pleasure to welcome the next panel. We will start from my left. Dr. Nancy Dickey from Richmond, TX is a board-certified family physician who practices at the Fort Bend Family Health Center in Richmond, TX. Dr. Dickey is currently vice chair of the American Medical Association Board of Trustees, and prior to her election to that board, she served as a member of the AMA Ad Hoc Committee on Women in Organized Medicine.

Next, Mr. Tom Scully is president and CEO of the Federation of American Health Systems. He is very familiar to us here as he has worked on a number of legislative endeavors. The Federation where he now serves as CEO represents the Nation's 1,700 investor-owned and managed hospitals and health systems. Mr. Scully previously served as deputy assistant to President Bush for domestic policy and counsel to the director of the Office of Management and Budget under President Bush, where he worked on President Bush's malpractice reform legislation.

Laura Wittkin is executive director of the National Center for Patients' Rights. The National Center for Patients' Rights is a medical malpractice victims' and patients' rights advocacy and support group. We welcome you, Ms. Wittkin.

We will start with Dr. Dickey.

STATEMENTS OF DR. NANCY W. DICKEY, RICHMOND, TX, VICE CHAIR, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION; THOMAS A. SCULLY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, FEDERATION OF AMERICAN HEALTH SYSTEMS, WASHINGTON, DC; AND LAURA WITTKIN, EXECUTIVE DIRECTOR, NATIONAL CENTER FOR PATIENTS' RIGHTS, NEW YORK, NY

Dr. DICKEY. Thank you, Madam Chairwoman and members of the committee.

As Senator Kassebaum said, my name is Nancy Dickey, and I am a practicing family physician and vice chair of the AMA's board of trustees.

I am pleased to testify today regarding S. 454. We commend Senators McConnell, Lieberman, and you, Madam Chairwoman, for sponsoring this important bill.

Physicians and health care providers applaud your leadership in seeking solutions in the current liability crisis. As you may know, the AMA has long been concerned about health care liability issues. Let me note for the record that we also are an active member of HCLA, the Health Care Liability Alliance, a coalition of nearly 30 groups working on Federal liability reform.

While the quality and safety of our Nation's medical care is unparalleled, a small number of medical injuries do occur. They are

inevitable as well as inexcusable. Although we have seen an unusual number of medical injury press reports as the momentum for this legislation has been building, let me assure you that the AMA strongly supports aggressive intervention to identify, deter and, where appropriate, punish, negligent acts.

The medical profession is committed to protecting patients and seeking a greater ability to police ourselves. But we need your help to further address these and other matters.

We are very pleased that S. 454 contains important building blocks to effective reform. They include limited Federal preemption, joint and several liability reform, modification of the collateral source rule, periodic payment of future damages, attorney contingency fee reform, and a cap on punitive damages.

While many of the provisions in S. 454 would advance health care liability reform, more is needed. Specifically, we would urge including a cap of $250,000 on noneconomic damages as the best way to achieve the full measure of needed relief.

Let me turn for a moment to why a cap on noneconomic damages is so essential to add to this mix. Every major independent study over the last 15 years has reached the same conclusion, namely, that enacting a limit on noneconomic damages is the most effective reform in containing runaway medical liability costs. These studies include those conducted by the OTA, the IOM, President Bush's Council on Competitiveness, President Reagan's Tort Policy Working Group, and President Carter's Department of Health, Education and Welfare.

Along these lines, we are thrilled that the House of Representatives recently passed a bill, including health care liability reform, with a $250,000 cap on noneconomic damages. We urge the Senate to do the same.

We believe that such a cap on noneconomic damages is both reasonable and desirable. A recent HCLA poll shows that 71 percent of the American people support limits on noneconomic damages. Even with this cap, the United States would be the most generous country in the world in terms of noneconomic damages.

Unfortunately, some groups are still spreading misinformation about all the good that such a cap would do. Let me briefly try to set the record straight.

First, it has been stated that a $250,000 limit on noneconomic damages would keep injured patients from being compensated. This is simply not true. The AMA strongly supports the right of injured patients to be made whole. The proposed cap in no way takes away the patient's right to sue. In fact, in California, where such a cap exists, claims frequency is increasing, and patients with severe and permanent injuries are collecting millions of dollars.

A second misconception is that victims of health care injury keep the lion's share of the moneys that are awarded in the cases. The sad truth, as you heard earlier today, is that on average only 43 cents of every dollar awarded goes to the patient, while the system—the lawyers—get over 50 cents on the dollar.

Third, it has been argued that a $250,000 limit on noneconomic damages would discriminate against homemakers because they do not have lost wages. This is false. The clear trend in the courts is

to calculate the full economic value of the domestic services and provide appropriate damages for that.

Fourth, it has been argued that a cap on noneconomic damages would do little to increase access to health care. Again, not true. In fact, escalating liability premiums and the threat of lawsuits have inhibited treatment availability and driven increasing numbers of physicians away from services that could save lives; I see it every day in the small towns in Texas around where I practice.

I hope you have seen our recent Washington newspaper ads featuring Dr. Maureen O'Regan. They illustrate the plight of a local ob-gyn who teaches at Georgetown here in the District, but she delivers babies only across the line in Virginia. Why? Because Virginia has enacted a liability reform cap. To practice in Washington, DC, where no cap exists, would cost Dr. O'Regan $70,000—more than double her liability premiums in Virginia and more money than many Americans make in a year.

In my own State of Texas, Dr. Antonio Falcon and his partners are the sole obstetricians in Rio Grande City, an area roughly the size of Rhode Island. In 11 years of practice, Dr. Falcon had never been sued, and then suddenly, he had eight suits in 2 years. The cases were eventually dismissed without payment, but the group was so drained it chose to stop delivering babies.

Madam Chairwoman, the plain truth is that our liability system must be reformed. While S. 454 takes several steps in the right direction, we urge amendment to add a reasonable cap on noneconomic damages.

Thank you. I would be pleased to answer any questions.

The CHAIRMAN. Thank you, Dr. Dickey.

[The prepared statement of Dr. Dickey follows:]

PREPARED STATEMENT OF NANCY W. DICKEY, M.D.

Madam Chairwoman and members of the committee: My name is Nancy W. Dickey, MD. I practice family medicine at the Fort Bend Family Health Center in Richmond, TX. I also serve as Vice-Chair of the Board of Trustees of the American Medical Association (AMA). On behalf of the 300,000 physicians and medical students of the AMA, I am pleased to have this opportunity to testify before you today regarding the Health Care Liability Reform and Quality Assurance Act of 1995, S. 454. We commend Senators McConnell, Lieberman, and you, Madam Chairwoman for sponsoring this important legislation and for recognizing the importance of liability reform and patient safety.

The AMA has long been concerned about health care liability issues, in particular. Let me note for the record that we also are an active participant in the Health Care Liability Alliance (HCLA), a coalition of nearly 30 organizations which support health care liability reform.

Along with the important issues raised in the McConnell/Lieberman bill, I urge this committee to go further in addressing the waste and inefficiency inherent in the existing health care liability litigation system. By accepting this challenge and enacting meaningful medical liability reform, this committee has the opportunity to increase access to medical services, eliminate much of the need for medical treatment motivated primarily as a precaution against lawsuits, improve the doctor/patient relationship, help prevent avoidable patient injury, and curb the single most wasteful use of precious health care dollars—the costs, both financial and emotional, of health care liability litigation. A narrow amendment adding a $250,000 cap on noneconomic damages to the McConnell bill would go extremely far toward answering these issues head on, and would strengthen a bill which is already good in many respects.

The existing litigation climate in this country poses a grave threat to the delivery of health care and, specifically, to the relationship between physicians and patients—a relationship that must be founded on trust and cooperation if it is to be successful. While the quality and safety of our nation's medical care is unparalleled,

we must all dedicate ourselves to eliminating the small number of patient encounters where medical injuries occur in the course of receiving health care services. While some of these injuries may be unavoidable, a fraction do involve a breach in the standard of care every patient has a right to expect. When such an injury occurs, we believe the patient is entitled to prompt and fair compensation. For our part, the health care community is obliged to demonstrate an effective risk management response designed to prevent the injury from happening again. This response may involve professional discipline of the physician or other health care provider responsible for the injury. We urge this committee and this Congress to do all that it can to restore to physicians the full ability to police the practice of medicine. In working to reach that end, health care liability reform is our best present hope for promoting patient safety, ensuring fair compensation to those patients who are wrongfully injured and reigning in the "lottery mentality" that drives our tort system today.

As you know, our health care liability system is neither speedy nor consistent in delivering compensation. Transformed by high stakes financial incentives, it has become an increasingly irrational lottery. RAND Corporation research shows that juries give consistently higher non-economic damage (e.g. "pain and suffering") awards in medical liability cases than in other personal injury cases where comparable injuries are alleged. A few patients, and their attorneys, actually become multimillionaires as the result of a single judgment or settlement, while most persons with valid claims appear to be blocked from even gaining access to the civil justice system. Even when patients recover an award, U.S. General Accounting Office (GAO) studies show that they often fail to net their out of pocket losses, after contingency fees and legal expenses are deducted. Looking at the costs of the system overall, only 43 cents on the dollar is paid in compensation to deserving claimants. In comparison, the Medicare program or even the widely-criticized workers' compensation systems are much more cost-effective, delivering at least 75 cents on the dollar in patient benefits.

Sadly, doctors have learned that being sued goes hand-in-hand with practicing medicine or dentistry no matter how skilled they may be in the quality of care delivered. In fact, the health services sector has a higher frequency of liability claims than any other segment of society. Roughly one-third of all doctors, fifty percent of surgeons and seventy-five percent of obstetricians get sued at least once in their careers. Ironically, upwards of three-quarters of these cases have absolutely no merit and are closed with no payment to the claimant.

The psychological and financial costs of defending these claims are staggering. Physicians are prompted—by their own experience or that of their colleagues, by their hospitals' risk managers, by aggressive lawyer advertising and many other aspects of our culture—to assess every patient as a potential litigant and to approach him or her defensively. These defensive practices add billions to our nation's health care bill every year.

According to a report prepared by Lewin-VHI released in February 1993, comprehensive medical liability reform as a component of health care delivery system reform could save an estimated $35.8 billion over the next five years by curbing premium cost and many defensive medical practices, such as C-sections. Once achieved, the Lewin study predicts that tort reform savings will accrue at an accelerated rate as practice patterns begin to change.

Clearly, much remains to be done at the federal level. Every recent poll has demonstrated that the American public strongly supports effective health care liability reform as a component of health system reform. According to a 1991 Gallup Poll, 77 percent of Americans think malpractice lawsuits and awards are an important reason for the rising costs in health care. The Los Angeles Times found that given seven possible reasons for expensive health care in this country, people are most likely to name malpractice suits. Studies conducted by the Harvard School of Public Health, the General Accounting Office (GAO), and the Department of Health and Human Services Task Force on Medical Malpractice and Insurance, just to name a few, concur with the following consensus: The current tort system, without substantial modification or reform, is unable to resolve medical liability claims effectively and efficiently.

We are pleased that S. 454 contains a number of health care liability reforms which we wholeheartedly support including: a limited preemption approach that would establish a recommended federal "floor," yet leave states substantial discretion to implement additional reforms or alternative schemes that are equally effective; joint and several liability reform for non-economic and punitive damages; modification of the common law collateral source rule to end the double recovery of damages; periodic payment of future damages; attorney contingency fee reform and a cap on punitive damages. Because access to obstetrical care is seriously threatened

by health care liability concerns, we are encouraged by the special attention in the bill given to medical liability lawsuits filed against health care professionals who deliver babies without the opportunity to treat the mother during her pregnancy.

The medical community—and the medical liability community—is committed to continuing efforts to further reduce the incidence of injury and strongly supports reform efforts to promote patient safety which we believe are of the utmost importance and are the particular responsibility of the health care community. We are concerned, however, with the bill's mechanism to achieve this end through an "opening" of the National Practitioner Data Bank because of the flawed nature of its operations and the lack of safeguards to ensure the accuracy of its information. The AMA strongly supports required risk management training for health professionals as outlined in S. 454. However, most physicians already are practicing subject to such requirements imposed by the hospitals and clinics in which we practice or by our liability insurers. These entities already have substantial incentives to reduce injury. It is not clear cut that additional federal regulation is needed. What is clear is that physicians must be actively involved in developing and participating in risk management activities in order to achieve the goal for which they are created—providing high quality patient care.

While we are heartened by the health care liability reforms included in S. 454, we believe these reforms could be further strengthened by adding a reasonable cap on non-economic damages. A cap of $250,000 on non-economic damages is crucial to effective and sensible liability reform. Polls consistently show strong support for such reform. In fact, a recent poll conducted by the HCLA shows that 71 percent of the American people support limits on non-economic damages. The recent action in the House proved that including a cap of $250,000 on non-economic damages is not an impediment to passing lawsuit reform legislation dealing with product liability reform.

By international standards, the proposed $250,000 limit is generous. No other developed country compensates victims of health care injuries as generously for their non-economic losses. Even with a cap of a quarter of a million dollars, the United States would be the most generous country in the world in terms of non-economic damage awards.

The Physician Payment Review Commission in its 1994 Report to the Congress stated that "[much] of the unpredictability and inconsistency that characterize today's malpractice awards is because of non-economic damages (i.e. pain and suffering), which account for about 50 percent of total payments. Such damages are highly subjective. Reducing the unpredictability and eliminating the potential for unreasonably high awards would improve decisionmaking during the course of a lawsuit and promote settlement. Almost half the states have no statutory limits on non-economic damages." Limits on non-economic damages are the single most effective reform in containing medical liability premiums, according to a September 1993 report by the Office of Technology Assessment (OTA).

A study conducted by Patricia Danzon, a well known scholar in this area, concludes that a cap on non-economic damages reduced claims severity 23 percent on average over the decade in which she studied claims. A new study by the actuarial firm of Milliman and Robertson confirms these results. While the majority of cases were unaffected by the limits, limits on the few very large awards had a significant effect on the total payment of claims. Indeed, the GAO found in 1984 that just 2 percent of medical liability cases produce the large awards for "pain and suffering" damages which add tremendously to our health care costs. Yet, these cases accounted for over 60 percent of the payouts, showing that they were outliers.

The California medical liability law (MICRA), adopted 20 years ago, which includes a $250,000 cap on non-economic damages screens out "lottery" awards and demonstrates that such a limit brings down costs, while maintaining the patient's right to be made whole.

Prior to the enactment of the $250,000 ceiling on non-economic damages in California, the state had the highest liability premiums in the nation. California's premiums are now one third to one half those in New York, Florida and other states that have not established such limits. In my own state of Texas, where no cap on non-economic damages exists, we have a true access to care crisis for poor persons because of the unrestrained growth in liability premiums.

There are those who argue that a $250,000 cap on non-economic damages will keep deserving patients from getting the million dollar settlements they may deserve. This is simply untrue. In fact, patients with valid claims are collecting millions of dollars now in California, despite the state's $250,000 cap on non-economic awards. The number of million dollar verdicts and settlements has hovered around 30 per year in the 1990s, with the average indemnity in these cases near $2 million. These million-dollar plus cases include awards for wrongful death, birth injuries, di-

agnosis related errors, failure or delay in treatment and substandard post-surgical care. The California system proves that patients who suffer severe injuries will not be left out in the cold.

Even with these million dollar awards to deserving claimants, the $250,000 cap on non-economic damages has had a positive impact on the costs associated with defensive medicine. An AMA survey of physicians nationwide found that California physicians practice less wasteful defensive medicine—30 percent less.

In addition to the costs associated with our current liability system, access to higher risk medical services, such as obstetrics, is a real liability issue. Increasing premiums and the threat of liability have caused physicians to abandon practices and to cease provision of certain services in various areas of the country. Access to health care includes: (1) the availability of a physician or other health care professional to treat a patient; (2) the willingness of the physician or other professional to treat a patient; and (3) the affordability of the medical services.

Physicians and health care institutions have limited their medical practices in response to the liability climate. According to a 1990 membership survey completed by the American College of Obstetricians and Gynecologists, almost one out of eight obstetrician/gynecologists (12 percent) has dropped obstetrical practice as a result of liability risks. A 1990 OTA Report noted that more than a half million residents of rural counties are without any physicians who provide obstetric services. Without significant liability reforms, both rural and urban areas suffer the consequences.

A recent issue of *Medical Economics* featured my own state of Texas as the state with the most malpractice claims filed in the country. The article entitled, "Where doctors get sued the most" indicates that while the percentage of Texas doctors with claims filed against them rose to double the national average in 1992, the percentage of cases which resulted in indemnity payments was the same as in most states. In other words, the lawsuit lottery is "big" in Texas, and patients are not the winners.

The article profiles Dr. Antonio Falcon, M.D., a colleague of mine in Rio Grande City, who, along with his partners, are the sole providers of obstetrical care in the area. Dr. Falcon testified last year before the House Judiciary Committee on liability reform. In eleven years of practice, he had never been sued until the litigation explosion of the 1990s when he was sued eight times in two years. The article notes that while the cases were eventually dismissed with no payment, it was so emotionally draining that Dr. Falcon and his group announced it would quit delivering babies.

In Missouri, there are 29 counties where there is no doctor to deliver a baby and 74 counties where there is no OB/GYN doctor, according to a FY 90 Health Manpower Shortage Area (HMSA) survey. In fact, according to a book written by the Institute of Medicine entitled, Medical Professional Liability and the Delivery of Obstetrical Care, the delivery of obstetrical care in all rural areas is seriously threatened by professional liability concerns.

In urban areas such as Washington, DC, obstetricians in Northern Virginia, where a reasonable limit on health care liability awards exists, found they cannot afford to practice in the District where malpractice insurance costs more than most people earn in a year. While the desire to provide health care services in DC is there, the risk is too great.

In recognition of the need for increased access to care, the National Council of Negro Women is supporting the AMA and the Health Care Liability Alliance in its efforts to reform the medical liability system, "including a cap on non-economic damages as part of comprehensive legal reform legislation." The Council members recognize that low-income minority communities are facing increasing shortages of minority physicians who cannot afford to serve Medicaid patients and pay the required liability insurance.

The proposed cap of $250,000 on non-economic damages in no way takes away a patient's right to sue in the event of a medical injury. In fact, the AMA strongly supports that right. People must be compensated fully and fairly for any economic losses such as medical and rehabilitation costs, lost wages and other out of pocket costs associated with the injury. In some cases, this has even included building a "handicap friendly" house for a person who has been seriously disabled by a health care injury.

If a homemaker, for example, sustains an injury which renders the individual unable to perform services for a family, case law reflects that although there is no weekly paycheck, there is an economic value attached to running a household and raising a family. These valuable and necessary services are quantifiable, as opposed to noneconomic damages, and should be justly compensated. Likewise, children who are injured should also be compensated for economic losses to the fullest extent possible so that a child's future earnings are fully and fairly taken into account. Just

as we would advocate for our own family members, there's no question that injured patients should be fully compensated for the cost of their care, present and future wages and other economic losses.

In closing, every participant in the medical liability system has the opportunity and the responsibility to make the system work better. The medical community is actively carrying out its responsibility to identify high-risk of injury situations and aggressively address them through a variety of patient safety and loss prevention programs in virtually every medical setting. Unfortunately, however, America's physicians can do little to remedy the waste in our dysfunctional tort system. We earnestly hope that the members of this committee will heed the call to participate in this effort and fashion a liability reform package which strengthens the provisions of S. 454 by adding a $250,000 cap on non-economic damages.

The litany of problems with the current ton system does not necessarily mean that the system must be abandoned. The AMA believes that a fault-based system that lowers the barriers to legitimate claims and reduces transaction costs as described above can meet the needs of society. Reforms such as those adopted in the states of California and Indiana tell us that the current system is a good candidate for reform, and that reform can produce dramatic effects by promoting settlement of valid claims, discouraging frivolous litigation, and reducing the time required for claims resolution.

A virtual consensus exists among physicians, other health care professionals, and institutional providers that strong traditional tort reform represents an important and necessary step toward reaching a more rational, cost-effective means for resolving medical liability claims. Our liability system needs to be fixed to meet the needs of the injured patients who deserve to be fairly compensated, the physicians who are willing to assume their fair share of the burden from negligent practice, and society, which needs to reduce transaction costs, eliminate windfall judgments, and assure that physicians can still offer medically necessary services in an atmosphere of fairness to all parties.

The AMA appreciates the opportunity to appear before this committee. As the committee moves toward marking up S. 454, we ask that in addition to the health care liability reforms provided in the legislation, you also include a $250,000 cap on non-economic damages. At this time, I would be pleased to answer any questions.

The CHAIRMAN. Mr. Scully.

Mr. SCULLY. Thank you, Madam Chairman.

I am here to testify today as a member of the board of the Health Care Liability Alliance and also for the Federation's 1,700 investor-owned and managed hospitals.

The liability issue has been at the top of the hospital agenda for over 20 years, and there has been virtually no movement. This year, with the passage of the House bill, we see the best chance for passage in a generation.

My hospitals did not expect the House bill to pass by 100 votes, and to be honest with you, I think we were a little bit timid in our approach to advocating malpractice reform earlier this year, and I can assure on behalf of all the hospital organizations that that will not be the case for the rest of the spring. We are very actively and aggressively pushing for malpractice reform.

Thanks to the patience of one of my former bosses, Senator Gorton, I managed to go to law school at night while I worked in the Senate, and I have practiced law in a law firm for 5 of the last 10 years. I also have a brother who is a trial lawyer. I have spent most of the last 10 years working on health care issues. So I think I have seen this issue from just about all sides, and my conclusion is that the real issue here is very clear. The real issue is trial lawyers' incomes versus reasonable rules for compensating and protecting patients.

As you mentioned in your statement, Madam Chairman, 43 cents on each dollar, according to RAND, actually goes to plaintiffs; the rest goes to court costs. For years in the political arena, the trial lawyers have been winning this battle both at Federal and at State

levels. We hope that with the election last fall that there is a bipartisan sense that this is not time for politics as usual, and we are hopeful that we will see aggressive change in Congress.

We appreciate the chairman's bill, and we thank the chairman along with Senators Lieberman and McConnell for aggressively trying to push reform and malpractice reform.

Just to give you one example of a State where malpractice reform has been in place for over 10 years—California—where MICRA was passed in 1975 and actually implemented in 1985 after countless legal challenges, California's law includes noneconomic damages capped at $250,000, it includes fair share liability reform, it includes collateral source reform and installment schedules for future payments to plaintiffs, and attorneys' fees that are limited on a sliding scale. These are perceived as fairly aggressive reforms, but I would argue that they are actually fairly modest.

We have 191 hospitals in California represented by my association. I have represented a number of California health plans for the last few years, and I can tell you from my experience that I have yet to see any trial lawyers panhandling in the streets of Los Angeles. We have seen very little backlash in California, public backlash or any increase since 1985 in the number of patients who claim they have been treated unfairly. And still, in a recent poll, 75 percent of Californians supported the MICRA reforms that were implemented in 1985.

California is actually a fairly mild State. Seven States cap overall total awards. In fact, the State that I live in and I am sure many people in this audience live in, Virginia, has an overall cap of $1 million on all malpractice awards. Seven States have caps of $1 million or below—much, much more aggressive than anything that we would advocate or anyone on this panel would advocate—and yet I do not think it has been an enormous problem in Virginia.

We cannot say that malpractice does not exist. It does. It exists in my hospitals, it exists in hospitals all over the country. The fact is that patients need to be compensated, they need to be protected, but there has to be a rational system to make sure it is dealt with in a fair and equitable way.

One of my hospital chains, a large multihospital chain, has over 1,000 outstanding malpractice claims today. More than two-thirds of those claims will be dismissed without any award or settlement to the plaintiff, without any substantial legal action. The award of that only goes to that attorneys; the costs go to society.

Trial lawyers organize and fund virtually all opposition to malpractice reform, and they always have. They are obviously very smart, very tough, very well-funded, and they have been very successful for years. I happen to think that substantively, they are very wrong.

We believe that the chairman's bill is a great step toward a rational liability system. We strongly support the issues of fair share reform, periodic payments for future damages, limitations on attorneys' fees, punitive damages limitations, and the preemption language that will allow States like California to maintain stronger legal provisions.

We also support additional provisions such as the $250,000 cap that California has on noneconomic damages which are not in-

cluded in the chairman's bill, but we think your bill is a great start nevertheless.

These are not new or radical concepts, or for me, new positions. You mentioned that in 1991, I helped draft President Bush's liability reform bill—which I have brought copies of today, and not that we did a lot of things right; we did lots of things wrong in the Bush administration—but one of them I think was this—and I think you will find that the positions in President Bush's bill were very well-received on a bipartisan basis then. It was good policy then, good bipartisan policy then and still is today, and I think you will find that they are virtually identical, word for word, to what HCLA, the organization I am representing today, is for.

There are a number of Senators politically—my former boss, Senator Gorton, I believe, is one—who are concerned that malpractice reform might have the impact of slowing down and bogging down the product liability bill that they have been working on for years. I am certain that that is what the trial lawyers are praying will happen. I really, truly believe that once Americans understand that malpractice reform is actually on the table and might actually happen this year, you will find there will be a strong public outcry to include malpractice reform and that it actually will be a major, major help in getting votes for a liability reform package, not a hindrance.

In conclusion, we really believe that this is an issue not of trial lawyers versus doctors, but of the average American versus trial lawyers. I can assure you that hospitals—and I speak for the AHA, the Federation and every other major hospital organization—and their 4.3 million employees will be aggressively working for malpractice reform this year. We are 100 percent behind your efforts, and I think you will find that in most communities, we are the largest employer.

Trial lawyers have managed to get Congress to back off on liability reform for 40 years. Our hospitals and our allies in the Health Care Liability Alliance intend to ensure that for once, the public and not the trial lawyers win.

Thank you, Madam Chairman.

The CHAIRMAN. Thank you, Mr. Scully.

[The prepared statement of Mr. Scully follows:]

PREPARED STATEMENT OF THOMAS SCULLY

Madam Chairman and members of the committee: My name is Tom Scully. I am President and C.E.O. of the Federation of American Health Systems, an association of the nation's 1700 investor owned ad managed hospitals. I am testifying on behalf of the Health Care Liability Alliance. We have been working with the Alliance to enact comprehensive reform of the health care liability system at the federal level.

The Health Care Liability Alliance (HCLA) is a coalition of physicians, hospitals, other health care givers, insurers, manufacturers, organizations and individuals who believe that our country's dysfunctional system for resolving health care liability disputes is a national problem that demands a national solution. A list of the members of HCLA is attached (Appendix A).

We thank the the committee for holding this hearing and allowing us the opportunity to testify. We also commend the Chair, Senator Kassebaum, and Senators McConnell and Lieberman for their commitment to improving the health care liability system and health care quality, as evidenced in the legislation they have introduced, S. 454, the "Health Care Liability Reform and Quality Assurance Act of 1995."

I am also pleased to be here as a representative from the hospital community and to reaffirm hospitals' longstanding commitment to seeking reform of our inefficient

tort system. As the momentum for liability reform, and specifically health care liability reform, grows, we believe that Americans have the best opportunity in twenty years to address this serious problem. I know I speak for the American Hospital Association and the National Council of Community Hospitals, as well as the Federation, in saying that this spring hospitals will be coming out with an even greater force and intensity to help make these reforms a reality.

For years, the public has clamored for these reforms. Hearings were held on this subject in the Senate Finance and Judiciary Committees last Congress. This distinguished Committee also held a lively and informative discussion on this subject during mark-up of health care reform legislation in the last Congress. Already in this Congress, the House Judiciary Committee held hearings on legal reform that addressed many of these issues and the House just completed floor debate and passage of legal reform that included health care liability reform.

The refrain we most often hear from the opponents of these reforms is based upon examples of tragic injuries suffered by patients. These tragedies are compelling, but the emotional response to them, misses the point of this debate.

Medical injury, and medical malpractice do occur. Human beings make mistakes and in medicine they can be tragic. But the existing system falls miserably in addressing this issue.

- It fails to reduce medical injury or medical malpractice, in anything but a haphazard way.
- It fails to compensate many who are injured, and overcompensates many others.
- It adds enormous costs and inefficiencies to an already expensive and inefficient health care system.
- It benefits lawyers excessively at the expense of injured plaintiffs.
- And it threatens access to care.

S. 454 recognizes these problems in its findings, "the civil justice system of the United States is a costly and inefficient mechanism for resolving claims of health care liability and compensating injured patients." The findings state further that, "the problems with the current system are having an adverse impact on the availability of, and access to, health care services and the cost of health care in this country."

Let's be clear from the start, there are better ways to safeguard patient wellbeing. The real issue in this debate is trial lawyer income vs. reasonable rules for compensating and protecting patients. I have been a practicing lawyer for five of the last ten years, my brother is a trial lawyer, and I have worked in the health care field for years. I know these issues.

California is the most progressive state in the nation on malpractice reform. HCLA's reforms track California's. No trial lawyers have been spotted panhandling in the streets of Los Angeles, and there has been no political backlash or public outcry from patients claiming to be unfairly treated. In fact, an April 1992 survey revealed that 75 percent of Californians support the California medical malpractice reforms.

THE NEED FOR REFORM

Numerous reports document and support the failings of the current system. For example, the 1994 Physician Payment Review Commission (PPRC) Annual Report to Congress states that "[t]he medical malpractice system does not adequately prevent medical injuries or compensate injured patients." It also notes a "widespread concern that the current functioning of the malpractice system may promote the practice of defensive medicine and impede efforts to improve the appropriateness and cost effectiveness of care."

The Harvard Medical Practice Study, based on a review of 31,429 medical records in 51 New York hospitals, concludes that while only 280 patients suffered an adverse event due to negligence, only 1 in 16 received compensation from the tort liability system. On the other hand, at least half the claims that were filed were without merit—that is, 50 percent of the malpractice claims studied were not filed by a plaintiff who received negligent medical treatment. Similarly, of the over 101,000 closed claims and suits reported to the PIAA Data Sharing Project, only one third have any payments at all to the plaintiff. In other words, litigation is not doing a good job in sorting out meritorious claims from nonmeritorious claims and compensating those who were injured. These conclusions are reinforced by GAO's estimate that nearly 60 percent of all claims filed against physicians are dismissed without a verdict, settlement or payment to plaintiff (Medical Malpractice, Characteristics of Claims Closed in 1984, U.S. General Accounting Office, 1987) and by a recent study funded by the U.S. Agency for Health Care Policy and Research that

found no relationship between prior malpractice claims experience and the technical quality of practice by Florida obstetricians. ("The Relationship Between Malpractice Claims History and Subsequent Obstetric Care," *JAMA*, 272(20):1588-1591, November 23/30, 1994.) With so little correlation between the filing of lawsuits and physician negligent behavior, such a system is not effective in deterring medical injury or negligence.

Our system is costly and wasteful. In fact, the United States has the world's most expensive tort system. At 2.3 percent of GDP, U.S. tort costs are substantially higher than that of any other country and two and one half times the average of all developed countries. (Tort Cost Trends, An International Perspective, Tillinghast 1992.) The Hudson Institute published a study in April 1994, co-authored by then Hudson Senior Fellow, Representative David McIntosh (R-IN) and Research Analyst David Murray, that examines the effect of liability on a large urban hospital in Indiana. The study concludes that "legal liability has become a key factor driving up the costs and decreasing the quality of medical care in the United States." The direct and indirect costs of liability added a total of $450 per patient admitted to the hospital, increasing medical costs at the hospital by 5.3 percent. On the physician side, while nationwide trends are mixed, medical liability insurance premiums continue to outpace inflation by substantial margins in states that have not achieved effective liability reform. For example, malpractice premiums increased by 14 percent in New York in 1993.

A particularly ominous trend in today's health system is an increase in the frequency of claims against primary care physicians, who play an ever larger role in the delivery of managed health services. While the scope of liability exposure in managed care continues to evolve, it is clear already that these large delivery systems and health care organizations are targeted as "deep pockets." In 1993, a California jury awarded $89 million to the family of a woman who was denied an experimental treatment for advanced breast cancer. Most of the award was punitive and noneconomic damages. Even if the defendant's behavior was wrong in this case, the system cannot withstand many awards of that magnitude. These excessive liability awards drive up the cost of health care and threaten access to care.

And the problem continues to get worse. Even in states like California, that have strong health care liability reforms in place and who see moderation in the growth of the cost of medical liability insurance, the number of cases brought has continued to increase. There were 16.5 percent more cases reported than in 1992. That number has increased by 54 percent since 1989. (See the 1993 California Medical Malpractice Large Loss Trend Study, published by the Medical Underwriters of California.)

Thus, the PPRC Report, the Harvard Medical Practice Study and the Hudson Institute Briefing Paper, to which could be added a host of other reports by the General Accounting Office (GAO) and the Department of Health and Human Services Task Force on Medical Malpractice and Insurance, and others, collectively demonstrate that the current tort system is unable to resolve medical liability claims cost effectively and makes only a haphazard contribution to deterring negligent behavior or improving the safety of care.

THE AMERICAN PUBLIC WANTS REFORM

People know the liability system is out of control. Every recent poll has demonstrated that the American public strongly supports effective medical liability reform. A 1995 Poll conducted by the HCLA in the week of March 10, 1995, shows large majorities of the public favor a variety of health care liability reforms, such as placing limits on the amount that can be awarded for losses like "pain and suffering," limiting the percentage that a personal injury lawyer can receive as a fee from any settlement or award for his client, and disallowing lawsuits to award plaintiffs money for items for which they have already been compensated. The *Los Angeles Times* found that given seven possible reasons for expensive health care in this country, people are most likely to name malpractice suits. According to a 1991 Gallup Poll, 77 percent of Americans think malpractice lawsuits and awards are an important reason for the rising costs in health care.

A BETTER WAY

Given the magnitude of the problems with the current system, a dialogue on how to improve the system has been ongoing for many years. There is a broad consensus among scholars, the public and elected representatives on the objectives of health care liability reform and a developing consensus on the means to achieve those objectives.

1. Patient Safety Should be Promoted.

HCLA believes that any reform of the liability system must be built upon meaningful patient safeguards against medical malpractice or harm from medical products or services. The key to patient safety, is not trial lawyers and litigation. Rather, it is work that has been long underway in the medical community. There has been a revolution in the delivery of health care services since the Harvard Study was conducted ten years ago. Our health care system then was distinctly different than it is today. Hospital payments under Medicare were being constrained for the first time, and traditional independent, fee-for-service medical practices were commonplace. Little or no emphasis was placed on systemic quality, outcomes research or centralized medical management. Today, hospitals are clearly operating in a different environment where capitated payments are the norm, and solo fee-for-service medical practices are increasingly being displaced by large networks of physicians and other providers. Roth public and private sector payers are demanding systemic quality measurements that can continually demonstrate better outcomes and healthier patients.

It is in this atmosphere that patient safety and risk management programs have been established and are flourishing—this trend has been an unanticipated benefit of private sector health care reform. HCLA members come from all aspects of the health care system and an overview of their risk management and patient safety activities will give the Committee a sense of the new environment. First of all, let me emphasize that risk management requires significant investment by hospitals, as it does of every HCLA member which conducts risk management activities. We know, though, that risk management is a sound investment because it improves the quality of services provided to patients, it decreases unnecessary health care costs incurred when patients suffer complications or additional injuries as a result of substandard care or when preventable health risks go unaddressed, and it promotes advances in medical treatment and technology designed to minimize patient exposure to risk. Examples of risk management activities include:

—Hospitals hiring full time risk managers who identify risk factors and help design plans to eliminate or mitigate them.

—The Physician Insurers Association of America, a national association of physician-owned medical professional liability insurance companies, routinely collecting and disseminating new knowledge regarding the prevention of medical misadventures through its Data Sharing Program.

—Harvard Medical School, and other medical educational institutions nationwide, developing practice standards regarding for anesthesiologists, thereby improving anesthesiology for patients across the country.

The results of these activities are extremely encouraging. Anesthesiology has become many times safer in recent years because of the voluntary development, more than 10 years ago,of practice standards by the Harvard Medical School, for use in its affiliated hospitals, and adoption of those standards soon thereafter by the American Society of Anesthesiologists (ASA). Since then, insurance companies, managed care organizations and even a number of state medical regulatory authorities (e.g., New York, New Jersey) have adopted substantially similar standards. Before implementation by the Harvard Medical School of the anesthesia standards in July 1985, there was 1 intraoperative accident for every 75,700 anesthetics administered and 1 death for every 151,400 anesthetics administered between January 1976 and June 1985. Afterwards, between July 1985 and June 1990, there were no deaths at all and only 1 intraoperative accident for all 392,000 anesthetics administered. (See, "Risk Reduction in Anesthesia," *Anesthetic Risk and Complications*, 6(2):289, June 1992).

There are many other examples of risk management/inquality improvement activities which are driving the trend toward reducing the potential for medical injuries that might result in a health care liability lawsuit. Speaking on behalf of the millions of hospitals and hospital employees, physicians, pharmaceutical manufacturers, insurance companies and medical product makers I can honestly say that the investment in risk management and quality improvement is far less costly—from both a humanity perspective and a fiscal perspective—than the price that any pay when a patient is injured or dies due to substandard medical care or medical negligence during the course of medical treatment. Being dragged into a health care liability suit is costly and time-consuming—but worse than all of that is the deep regret felt by hospitals, doctors, medical device makers and other health care providers when they are responsible for harming a patient. The vast majority of health care providers are committed to helping to alleviate illness and suffering for all Americans seeking medical treatment—risk identification and prevention is, by far, the preferable alternative to counterproductive litigation for which every patient pays on every doctor and hospital visit.

2. Injured Patients Should be Fairly Compensated, and the System's Focus Should be on Their Compensation, not Lawyers.

People injured in the course of receiving health care treatment are entitled to fair and timely compensation. The litigation system often can have the dual negative effect of both delaying and reducing the patient's recovery, since lawsuits can take years and a large percentage of the award goes to pay court costs and legal fees. The RAND Corporation estimates that only 43 cents of every dollar spent in medical liability or product liability litigation reaches the injured patients.

Attached as Exhibit B to my testimony is an example of how the current system appears to serve lawyers more than patients. It is a final judgment order confirming a settlement agreement which involved a $200,000 cash payment to the plaintiffs (parents and injured minor), together with monthly payments for 20 years to the minor. Of the $200,000 cash payment, more than $160,000 was paid to the plaintiffs' attorney in expenses and fees, with less than $40,000 retained by the injured patient. Particularly striking is the fact that this case did not even go to trial, nor was it especially complicated or drawn out.

3. The Patient/Provider Relationship Should be Strengthened, Not Impeded.

If health care is delivered appropriately in all but a few hospital inpatient cases, our health care liability system should be designed to target those few cases. Instead it has run amuck and creates an overall climate of fear and suspicion that impedes developing trusting therapeutic relationships and fails to adequately address these problems.

4. The Liability Component of Health Care Costs Should be Contained

The high cost of health care liability that doctors, nurses, hospitals, product manufacturers, health insurers and others must pay in order to stay in business, is inevitably passed through into the prices of the products and services they provide. Total cost of medical liability insurance, including self-insurance is estimated at $9.2 billion, according to Lewin-VHI.

In addition to the actual cost of liability insurance, there are even greater costs associated with "defensive medicine"—diagnostic tests and services motivated primarily by the fear of litigation and the perceived need to build a medical record that documents a health care professional's decision. This factor is more difficult to quantify precisely, but is attested to by every health care professional. Lewin-VHI estimates the combined cost of physician and hospital defensive medicine to be as high as $25 billion in 1991 (Estimating the Costs of Defensive Medicine, Lewin-VHI, 1993.) To this you should also add the cost of liability borne by manufacturers of drugs and devices—$10.8 billion paid to claimants in health care product liability cases in the United States in 1990, not including the cost of liability insurance and legal defense costs. Thus the current cost of traditional health care liability exposures totals $45 billion a year and growing.

A final cost factor that is potentially enormous, but has not yet been calculated, is the liability of health insurers and health networks for their utilization review activities that restrict payment for health care services. Recent verdicts and settlement reports suggest that payers who refuse to provide services may be exposed to multi-million dollar suits, even if the medical service demanded by the patient has not been proven effective and is clearly excluded by the terms of the managed care plan. (See Patients' Lawyers Lead Insurers to Pay for Unproven Treatments, New York Times, March 28, 1994, page A1, attached as Appendix C.) This phenomenon can be thought of as an institutional equivalent to defensive medicine. Managed care organizations and health systems are being forced by the risk of excessive damage awards, like the $89 million award in California, to provide treatment that is not necessarily needed or effective.

5. Access to Health Care and Innovation Should be Promoted not Thwarted.

One of the most serious societal costs inflicted by the current liability system is reduced access to health care. Increasing premiums and the threat of liability have caused physicians and other health care providers to abandon practices or stop providing certain services in various areas of the country. More than a half million residents of rural counties are without any physicians to provide obstetric services. (Health Care In Rural America, Office of Technology Assessment, September 1990). Liability induced access problems have been most clearly documented among ob/gyn physicians. An Institute of Medicine report found that the high cost of liability insurance and the threat of malpractice litigation has a particularly adverse effect on the delivery of obstetrical services to three categories of women: those living in rural areas, those with high risk pregnancies and those who are poor. (See Institute of Medicine, *Medical Professional Liability*, vol. II, pp. 61–2, 1989.) Similarly, the Na-

tional Rural Health Association reports that many states and local communities are experiencing a serious lack of obstetric services and that increasingly this has been attributed to the medical malpractice problem.

Liability concerns are increasingly creating obstacles to the availability, affordability and innovation of medical drugs and devices as well. For example, in response to hundreds of claims filed against them, E.I. DuPont Company is restricting the sale of its Teflon product to the makers of lithium batteries used to power heart pacemakers. In this instance, even though it had no role in designing the device, because DuPont supplies the raw materials, it has been brought into lawsuits, most probably because of its deep pockets. DuPont and other companies are also restricting the sale of raw materials to manufacturers of jaw implants, artificial blood vessels, heart valves and sutures, among other devices. (Implant Industry is Facing Cutback by Top Suppliers, *New York Times*, April 24, 1994, page A1, attached as Appendix D.)

Until some reasonable limits are put on the liability exposure of defendants in health care injury cases—limits that provide fair, but not unlimited compensation for injured patients—these access problems will continue.

S. 454

S. 454 addresses these objectives and contains many of the reforms advocated by HCLA. HCLA strongly supports the elimination of joint and several liability for noneconomic damages so that the portion of such damages defendants pay is based on their degree of responsibility for the harm and defendants pay only their fair share of the damages based on their proportionate liability; reform of the collateral source rule to stop double recovery and the fraud and abuse that it generates; provision for periodic payment of future damages to more accurately effectuate the purpose of that compensation; limits on attorney contingency fees to protect injured patients from unfair expropriation of the money that is meant to compensate them; reform of punitive damages so that they bear some rational relationship to the harm done and won't hold up disposition of the underlying case. HCLA also supports further exploration of alternative dispute resolution mechanisms, such as Early Offer and Recovery, which will encourage settlements and reduce litigation.

Equally if not more important, S. 454 makes these reforms as a federal floor, and protects state law that goes beyond the federal floor. There are many states that have been leading the way on tort reform and they should be able to hold on to the gains they have made.

Finally, we want to express our support for applying S. 454's reforms to all potential defendants in disputes arising from injuries stemming from a health injury. The manufacturers of medicines and medical devices, providers of blood and tissue services or products, and health insurers and managed care organizations are all at risk of lawsuits when a patient is injured. Hospitals, clinics and other institutional providers are sued not just for malpractice, but for personal injury alleged to result from distribution of medical devices, drugs and blood tissue. Addressing the liability issue in just one part of the health care sector may actually stimulate litigation in other parts that are not subject to the reform provisions. Liability reform must encompass all potential defendants in claims arising from health care injuries.

Of course, there are nuances to the way provisions of legislation are drafted and we would appreciate the opportunity to work with the authors of the legislation and the members of this committee on the specific language and approach that would best effectuate these reforms.

ADDITIONAL REFORMS RECOMMENDED BY HCLA

In addition to the important reforms in S. 454, mentioned above, HCLA urges the committee to consider three additional reforms:

1. A $250,000 Cap on Noneconomic Damages

HCLA considers this to be the cornerstone of effective health liability reform. Limits on noneconomic damages are the single most effective reform in containing medical liability premiums, according to a September 1993 OTA Report. (See, Impact of Legal Reforms on Medical Malpractice Costs, Office of Technology Assessment, Sept. 1993.) Significantly, this cap on noneconomic damages does not in any way restrain the ability of an injured patient to recover any and all economic damages, such as medical expenses, lost wages, rehabilitation costs, replacement of domestic services, or any other out of pocket expenses. Noneconomic damages are inherently difficult to quantify and subjective by their nature, since they attempt to assign a monetary value to things intangible, such as pain and suffering, loss of enjoyment or loss of companionship. Finally, this reform is tried and true; it has been in effect in California, as part of their Medical Injury Compensation Reform Act (MICRA), passed in

1975, and has proven to be a great success both in providing fair compensation to injured patients and in keeping the cost of health care liability under control.

2. A Statute of Limitation Provision with a Statute of Repose

A uniform statute of limitation should be enacted that establishes a standard rule that claims must be filed within one year from the date an injury is discovered, but provides for an outside limit of three years from the date the injury occurred. Exceptions to these general rules allowing extra time should be made for children under age six who may not be able to communicate the existence of an injury, and for instances where a foreign object, with no therapeutic purpose is left in claimant's body. As in all areas of the law, there is a need for balance between the rights of those bringing suit, and the rights of those defending themselves. A statute of limitations which conceivably could permit a suit 23 years after a child is born cannot be interpreted by any reasonable person as striking the appropriate balance.

3. A Defense to Punitive Damages Claims Based on Compliance withGovernment Standards

Manufacturers and distributors of medical products that were subject to pre-market approval of the appropriate federal agency and marketed in accordance with federal regulations, or that met the "safe and effective" product requirements of the Food and Drug Administration, should have a defense against punitive damages on products for which they complied in good faith with these government requirements. Pursuing the lengthy FDA process and complying with the multitude of safety demands required by the Agency should shield a manufacturer from the quasi-criminal accusation of malice, or "conscious disregard of substantial and unjustifiable risk of unnecessary injury."

CONCLUSION

In conclusion, there is a better way to address health care liability issues. The public wants malpractice reform. Lawyers don't. HCLA's approach promotes and strengthens the important risk reduction efforts that the medical community has underway, while making needed reforms in the legal system as it applies to health care injury disputes. The current system is not working well for either patients or health care providers. We must get a handle on exploding liability costs and make health care more affordable and accessible. To do this we must correct the incentives and put us on a course to compensate injured patients fairly, cost-effectively and in a timely manner. S. 454 puts us solidly on that road, and with the addition of the $250,000 cap on noneconomic damages, a fair statute of repose and a government standards defense, we can bring the system back into line with the expectations and needs of patients and health care providers alike.

Appendix A

HEALTH CARE LIABILITY ALLIANCE MEMBER LIST
(Companies and Associations)

American Academy of Dermatology
American Academy of Ophthalmology
American Home Products Corporation
American Hospital Association
American Medical Association
AMA/Specialty Society Medical Liability Project
American Society of Healthcare Risk Managers
Biotechnology Industry Organization
Californians Allied for Patient Protection
Cooperative of American Physicians, Inc./Mutual Protection Trust
Council of Community Blood Centers
The Doctors' Company
Federation of American Health Systems
Health Industry Manufacturers Association
Health Insurance Association of America
Medical Liability Mutual Insurance Company
Medical Mutual Liability Insurance Society of Maryland
Medical Protective Company
MEDMARC Insurance Company
Missouri Medical Insurance Company
MMI Companies, Inc.
National Council of Community Hospitals
NORCAL Mutual Insurance Company
Pennsylvania Medical Society Liability Insurance Company
Pharmaceutical Research & Manufacturers of America
Physicians Insurers Association of America
PICOM Insurance Company
State Volunteer Mutual Insurance Co.

Appendix B

NO. 86-CI-10557

GILBERTO and ROSARIO ALVAREZ, Individually and as Next Friend of AURORA ALVAREZ, A Minor	•	IN THE DISTRICT COURT
VS.	•	45TH JUDICIAL DISTRICT
ROBERTO M. GONZALEZ, M.D., DR. ROBERTO M. GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER and RAMIREZ-GONZALEZ MEDICO-SURGICAL FAMILY CLINIC	•	BEXAR COUNTY, TEXAS

AGREED FINAL JUDGMENT

On this day came on to be heard the above-styled and numbered cause, wherein GILBERTO AND ROSARIO ALVAREZ, INDIVIDUALLY AND AS NEXT FRIENDS FOR AURORA ALVAREZ, A MINOR, are Plaintiffs; and ROBERTO M. GONZALEZ, M.D., DR. ROBERTO M. GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER AND RAMIREZ-GONZALEZ MEDICO-SURGICAL FAMILY CLINIC are Defendants.

It appearing to the Court that AURORA ALVAREZ is a minor, suing by and through her next friends, GILBERTO and ROSARIO ALVAREZ, both of whom also have individual claims, and the Court being of the opinion that there might be a conflict of interest between said Minor and her next friends, the Court has heretofore appointed Gene Toscano as Guardian Ad Litem for said Minor Plaintiff.

All Parties appeared by and through their respective attorneys of record and appearance was also made by the Guardian Ad Litem and all present announced to the Court that they had agreed to compromise and settle all matters in dispute and at issue between them, subject to the approval of the Court. It was further announced that the Guardian Ad Litem had made his investigation and had determined that the agreement of the Parties was fair and just and in the best interests of his ward, AURORA ALVAREZ, and that in the opinion of the Guardian Ad Litem said agreement should be ratified and approved by the Court. The Parties' written Compromise Settlement Agreement has been filed with the Court and examined by the Court. The Court further examined the pleadings and heard the evidence presented by the Parties regarding the occurrence made the subject of Plaintiffs' suit, the resulting injuries and damages alleged, the manner in which those injuries were alleged to have been received, and the nature, extent and effect of same. After considering all of the facts and circumstances and studying the Compromise Settlement Agreement executed by the Parties, their respective attorneys of record and the Guardian Ad Litem, and with the recommendation of the Guardian Ad Litem, the Court is of the opinion and finds that the Compromise Settlement Agreement is, under all of the facts and circumstances, fair and reasonable, that it is in the best interest of the minor child, AURORA ALVAREZ, and that such Agreement should be ratified and approved by the Court.

The Court further finds, after hearing all of the evidence, that the settlement consideration, both the present payments and future payments as herein set forth, are to be paid as full and final settlement of all claims of Plaintiff, GILBERTO and ROSARIO ALVAREZ, individually, and as Next Friend for AURORA ALVAREZ, a minor.

IT IS THEREFORE ORDERED, ADJUDGED AND DECREED by the Court that the Compromise Settlement Agreement filed with the Court is ratified and approved in all respects. IT IS FURTHER ORDERED by the Court that Plaintiffs GILBERTO and ROSARIO ALVAREZ, individually and as next friends for AURORA ALVAREZ, a minor, do have and recover of and from ROBERTO M. GONZALEZ, M.D., DR. ROBERTO M. GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER and RAMIREZ GONZALEZ MEDICO-SURGICAL FAMILY CLINIC, the sum of TWO HUNDRED THOUSAND DOLLARS ($200,000.00), out of which sum all attorney's fees and expenses of Plaintiffs herein, including those of the minor Plaintiff, are to be paid.

IT IS FURTHER ORDERED by the Court that Defendants shall make future payments to the minor Plaintiff AURORA ALVAREZ, by and through her legal guardian, in the amount of EIGHT HUNDRED FORTY AND 08/100THS DOLLARS ($840.08) per month. Said monthly payments shall commence on Apr. 26,1987 with all future monthly payments continuing thereafter payable on the first day of each and every month throughout the lifetime of the minor Plaintiff, AURORA ALVAREZ, or for twenty (20) years (240 monthly payments), whichever is longer. Beginning on April 26,1988, the monthly payments will be increased at the rate of 3% per annum, compounded annually and increased every year thereafter on the anniversary date of April 26 during the total time that such payments shall be made. In the event the minor Plaintiff, AURORA ALVAREZ, dies prior to March 26, 2007, then all future monthly payments, through and including March 26,2007, shall be made jointly to her parents, GILBERTO ALVAREZ and ROSARIO ALVAREZ. Unless otherwise provided, all future payments made in accordance with the terms of this judgment shall be paid to the legal guardian of the minor Plaintiff, AURORA ALVAREZ, for the use and benefit of AURORA ALVAREZ.

IT IS FURTHER ORDERED that TEXAS MEDICAL LIABILITY TRUST, the insurer of Defendants ROBERTO M. GONZALEZ, M.D., DR. ROBERTO M. GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER and RAMIREZ-GONZALEZ MEDICO-SURGICAL FAMILY CLINIC, as a matter of right, and in its sole discretion, may elect to assign the duties and obligations to make the future payments herein ordered to be made by Defendants ROBERTO M. GONZALEZ, M.D., DR. ROBERTO M. GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER and RAMIREZ-GONZALEZ MEDICO-SURGICAL FAMILY CLINIC; and that such assignment, if made, shall be accepted and binding upon Plaintiffs GILBERTO and ROSARIO ALVAREZ, individually, and as Next Friends of AURORA ALVAREZ, a minor, without right of rejection, in full discharge and release of the duties and obligations of ROBERTO M. GONZALEZ, M.D., DR. ROBERTO GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER and RAMIREZ-GONZALEZ MEDICO-SURGICAL FAMILY CLINIC and the TEXAS MEDICAL LIABILITY TRUST to make such future payments.

IT IS FURTHER ORDERED that if TEXAS MEDICAL LIABILITY TRUST elects to assign Defendants' and its duties and obligations to make the aforesaid future payments to METROPOLITAN PROPERTY AND LIABILITY COMPANY, Plaintiffs and the Guardian Ad Litem be, and they are hereby authorized, empowered and ordered to execute a "Release and Satisfaction of Judgment" as to ROBERTO M. GONZALEZ, M.D., DR. ROBERTO GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER, RAMIREZ-GONZALEZ MEDICO-SURGICAL FAMILY CLINIC and TEXAS MEDICAL LIABILITY TRUST. METROPOLITAN PROPERTY AND LIABILITY COMPANY shall thereafter be solely responsible for the duties and obligations to make such future payments.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that when ROBERTO M. GONZALEZ, M.D., DR. ROBERTO GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER and RAMIREZ-GONZALEZ MEDICAL SURGICAL FAMILY CLINIC or their insurer have paid the aforesaid sums presently due unto the Plaintiffs and TEXAS MEDICAL LIABILITY TRUST has made the assignment of Defendants' and its duties and obligations to make the future payments as provided for herein, that this Judgment shall be deemed fully satisfied, and Defendants ROBERTO M. GONZALEZ, M.D., DR. ROBERTO GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER and RAMIREZ-GONZALEZ MEDICO-SURGICAL FAMILY CLINIC and the TEXAS MEDICAL LIABILITY TRUST, and any agent, servant, employee or principal thereof, shall stand fully, finally and forever acquitted and discharged of and from any and all claims, demands or causes of action asserted in this cause, or which could, may or might have been asserted by GILBERTO and ROSARIO ALVAREZ, Individually, and as Next Friend for AURORA ALVAREZ, a Minor, by reason of the medical treatment, care and injuries complained of in Plaintiffs' Original Petition on file herein; and Plaintiffs and the Guardian Ad Litem are ordered to then promptly execute and deliver to said Defendants the aforesaid Release and Satisfaction of Judgment.

It appearing to the Court that the recovery of the Plaintiffs should be apportioned between the minor Plaintiff, AURORA ALVAREZ, Plaintiffs, GILBERTO ALVAREZ and ROSARIO ALVAREZ, and their attorneys, Tiemann & Houser, Inc., and after having heard the recommendations of the Guardian Ad Litem for the minor Plaintiff;

IT IS ORDERED, ADJUDGED AND DECREED that the recovery to the Plaintiffs in the sum of TWO HUNDRED THOUSAND DOLLARS ($200,000.00) in cash, and the future payments be apportioned as follows:

(1) The Plaintiff, GILBERTO ALVAREZ, have and recover from the Defendants the sum of $ 10,000.00 in cash;

(2) The Plaintiff, ROSARIO ALVAREZ, have and recover from the Defendants the sum of $ 10,000.00 in cash;

(3) The minor Plaintiff, AURORA ALVAREZ, have and recover from the Defendants the sum of $ 19,153.93 in cash; said sum to be paid to the legal guardian of the minor Plaintiff, AURORA ALVAREZ;

(4) The minor Plaintiff, AURORA ALVAREZ, have and recover from the Defendants future monthly payments as provided for herein; those being $840.08 per month, increasing at 3% per annum, the first payment to be Apr. 26,1987 and continuing for the life of AURORA ALVAREZ or twenty (20) years, whichever is longer;

(5) The attorneys for the Plaintiffs, Tinsman & Houser, Inc., have and recover the sum of $ 100,846.07 in cash as attorneys' fees for representing the Plaintiffs, GILBERTO ALVAREZ and ROSARIO ALVAREZ, and the minor Plaintiff AURORA ALVAREZ, in this action, said sum to include reimbursement of all expenses incurred and to be incurred on the Plaintiffs' benalf in this suit.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED by the Court that all costs of Court herein shall be paid by the Defendants, ROBERTO M. GONZALEZ, M.D., DR. ROBERTO M. GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER and RAMIREZ-GONZALEZ MEDICO-SURGICAL FAMILY CLINIC, including a fee of $5000.00, which shall be paid to the Guardian Ad Litem, Gene Toscano, for his services as such, and which said fee is hereby taxed as part of the Court costs in this suit and should be paid by said Defendants.

SIGNED this 18TH day of March, 1987.

JUDGE PRESIDING

APPROVED:

State Bar I.D. No. 20145000

GUARDIAN AD LITEM FOR AURORA ALVAREZ, A MINOR

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Ronald G. Hole
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ATTORNEYS FOR DEFENDANTS AND TEXAS MEDICAL LIABILITY TRUST

Appendix C

The New York Times

NEW YORK, MONDAY, MARCH 28, 1994

74 cents beyond the greater New York met

Litigious Patients Lead Insurers To Pay for Unproven Treatments

By GINA KOLATA

Pamela Schmale, a 39-year-old bookkeeper, says she felt that her only hope of surviving advanced breast cancer was to have a bone marrow transplant. But her insurance company said it would not pay for the expensive and risky procedure, which is still undergoing clinical testing.

In desperation, Mrs. Schmale and her husband, Arthur, mortgaged their house in Boring, Ore., to raise the $100,000 or more they would need for the transplant. And her doctors recommended lawyers who might fight their insurance company for them.

Cost of Legal Advice

The Schmales hired Sheldon Weinhaus, a lawyer in St. Louis who persuaded Mrs. Schmale's insurance company to pay the full cost of the transplant, which Mrs. Schmale had in January. Although Mrs. Schmale said her doctors told her it was too soon to know whether she would be helped, she was confident she had done the right thing. "I think it saved my life," she said.

In the last several years, patients have been increasingly turning to lawyers to pressure insurance companies to pay for claims that were initially denied, and some of the claims are even for treatments specifically excluded under their insurance plans. While this practice can help critically ill patients get access to treatments they desperately want, it raises issues of fairness, because the rewards go to those with the means to hire a lawyer.

Mr. Weinhaus said that lawyers charged, on average, about $10,000 for an insurance case and that they were not hired in such a case on a contingency basis.

The larger problem for society, some health care experts say, is that when litigious patients have their way, they hinder an important part of the effort to control health care costs: the attempt to stop paying huge sums for therapies that have no proven value.

But to litigious patients, no case is too advanced, no treatment is too expensive or too much of a long shot to be tried when the insurance companies pay the bill. And the companies, of course, merely pass the cost to the other policyholders by raising the insurance premiums.

The insurance companies usually agree to pay because of the cost of litigation and the chance that juries will impose large damage awards, said Dr. John Cova, a consultant on health insurance to the Health Insurance Industry Association. Even when a contract explicitly says the company need

Continued on Page A11, Column 1

Lawyers Used To Get Insurers To Pay for More

Continued From Page A1

not pay for an experimental treatment, a jury often sides with the dying patient. The companies "are getting weary," Dr. Cova said. "They keep losing."

Dr. Arthur Caplan, director of the Center for Bioethics at the University of Minnesota, said the process favored the rich over the poor and the assertive and the articulate over the reticent and reluctant. "Squeaky wheels get rewarded," he said.

This kind of litigation became popular a few years ago, said Karen Gallinari, a New York lawyer who represents patients against insurance companies. Now, Ms. Gallinari said, it is common. She said she rarely had to go to court. "In most of the litigation we've been involved in, we settle early on," she said.

Recently, Ms. Gallinari got a call from a woman with Lyme disease whose insurance company was balking at paying for an expensive experimental treatment. "I told her what to say, and the next thing I knew I got a call from her saying the insurance company had decided to pay," she said.

Examples of Legal Might

Examples abound of the power of the legal threats. Dr. William P. Peters, who heads a program at Duke University's medical school to treat advanced breast cancer with bone marrow transplants, reported that 19 of 39 women who had been denied payments persuaded their companies to pay after they hired a lawyer.

Dr. Thomas Spitzer, who directs the bone marrow transplant program at Massachusetts General Hospital, said that insurance companies came around after "a succession of women took their claims to court and won." Now, he said, "in the cases I am familiar with, they didn't even go to court." Just getting a lawyer was enough.

Dr. Curt Freed, who directs a program at the University of Colorado offering fetal tissue implants for patients with Parkinson's disease, said that insurance companies automatically refuse to pay for the $40,000 operation, but he added that five of eight patients who hired lawyers persuaded the companies to reverse their decisions.

"If we knew a way other than patients pressuring insurance companies and suing them, we'd be happy to follow that course," Dr. Freed said. "But it seems that the established procedure is pressure and lawsuits."

Dr. Caplan said he often questioned members of insurance company boards about how they decide when to deny payments. They use these four criteria: "Does this person have a lawyer? Is the person articulate? Have we already tried to say no at least once? Is this a person who can muster sufficient resources to give us a hard time, by getting media attention or starting a letter-writing campaign?"

Dr. Alan Garber, an internist and health economist at Stanford University, said companies tried to deny coverage for treatments like bone marrow transplants for advanced breast cancer because these therapies had not been proved effective.

"I would never blame people who have terminal illnesses and want to grasp at every straw," Dr. Garber said. But, he added, "the problem is that no one else is prepared to or able to say no."

Mr. Weinhaus said patients were not inclined to wait for science to declare that a promising treatment has crossed the line from experimental to proven. "When you're told that this is the only thing that will save your life, what are you supposed to do?" he asked.

But Mr. Weinhaus acknowledged that the system was unjust. "Why should my clients, who I would fight for to the bitter end, deserve more than anyone else?" he said.

Dr. Norman Daniels, an ethicist and health care specialist at Tufts University School of Medicine, said the country could simply not afford to pay for every treatment. Whether or not it is officially acknowledged, he added, rationing of medical care is a necessity.

"We are not obliged to provide wish fulfillment or the last chance at a miracle," Dr. Daniels said. "We are obliged to provided real assistance, and real assistance means something that works. When people say, 'If you don't do this, I'm going to sue you,' what they are doing is eroding any chance for society to say that we have got to draw a line."

Insurance industry spokesmen are dismayed by the situation. "In the current environment, it's virtually impossible or extremely difficult to ever say no," Dr. Cova said. Insurance companies are reluctant to fight their battles in court, he said, even when their contracts specifically say they are not obligated to pay for the treatments being sought, because of public sentiment. "Beating up insurance companies has become one of America's favorite indoor sports," he said.

Dr. Cova said patients and their doctors often paid no heed to the wording of health insurance contracts. He said, "The reasoning goes as follows: 'I want, and if I want something, I need it; if I need it, I have a right to it; if I have a right to it, someone else has an obligation to provide it.'"

Dr. Garber said he expected the legal battles to extend to treatments that were enormously expensive but that made only a slight difference in a patient's prognosis.

"What if bone marrow transplants allow women to extend their life expectancy from one year to 13 months, but it costs $100,000?" Dr. Garber asked. "Are we prepared to say that because we know it works, we will pay for it, no matter what it costs?"

"We can write an insurance contract that will not cover it, but it will not hold up in court," he said.

Appendix 3

New York Times, April 24, 1994, page A1

IMPLANT INDUSTRY IS FACING CUTBACK BY TOP SUPPLIERS

THREAT TO MEDICAL GEAR

Giants Like Du Pont and Dow Fear They'll Be Drawn Into Product Liability Suits

By BARNABY J. FEDER

Big chemical companies and other manufacturers of materials used to make heart valves, artificial blood vessels and other implants have been quietly warning medical equipment companies that they intend to cut off deliveries because of fears of lawsuits.

While the suppliers' new policies have not yet forced important products from the market, medical equipment makers that are scrambling to protect themselves from the impending cutoffs say they are having trouble lining up alternate suppliers. Industry executives and doctors say that the trend could eventually make some life-saving implants hard to come by and have a devastating effect on development of new devices.

About 100 equipment companies have already had supply problems, according to reports received by the Health Industry Manufacturers Association, the equipment makers' Washington-based trade group.

The materials manufacturers, including giants like E. I. du Pont de Nemours and the Dow Chemical Company, are dropping the medical business in response to the high risk of being dragged into lawsuits filed against implant makers by consumers who say they have been injured by defective products. Suppliers have already been named in hundreds of suits involving jaw implants, silicone breast implants and other devices.

Equipment makers say that the litigation that has prompted the suppliers to withdraw has also made it harder to obtain the materials indirectly through distributors or other middlemen. In addition, some equipment companies say electronics companies and other important subcontractors that assemble high-tech components for the most sophisticated implants are increasingly reluctant to take on such business.

"You can see a monster scenario where this gets totally out of hand," said Curtis Holmes, vice president for technology at Wilson Greatbatch Ltd. of Clarence, N.Y., a supplier of lithium batteries for heart pacemakers. Wilson is scrambling for a replacement for the pinch of Du Pont Teflon

Continued From Page A1

uses in each battery. Replacing the eflon could ultimately cost up to 300,000 in testing and regulatory earings and take researchers away rom developing products. But that is ot what really worries Mr. Holmes.

"What if the lithium companies de- ide they don't want to sell to us?" he sked. "Or the iodine, stainless steel r titanium producers?"

Despite behind-the-scenes lobby- ng, equipment makers and medical roups have so far raised little con- ern in Washington about the trend.

Consumer groups say the chemical ompanies' moves are simply part of broader campaign by industry to ressure Congress to limit the re- ress available in courts for those ijured by defective products. But ne leading supporter of legislation to verhaul product-liability rules has een convinced that the implant mak- rs' plight is a special case.

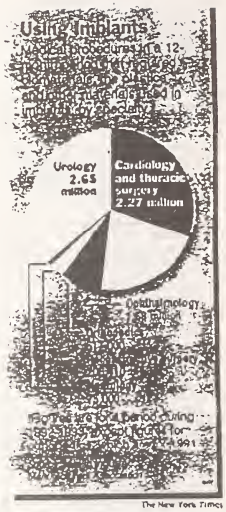
"This is a public health time omb," said Senator Joseph I. Lieber- nan, Democrat of Connecticut, who opes to hold hearings on the subject ext month. Senator Lieberman said hat although the proposed changes in roduct liability laws would reduce naterials suppliers' exposure to law- uits, the problem might have to be ealt with through specific language n the health care overhaul legislation eing written on Capitol Hill.

The medical equipment makers fear that partial protection from litigation will not be enough to bring back the big chemical and plastics suppliers because they have so little to gain from the medical business. Medical devices typically use small quantities of raw materials, compared with other applications.

Polyester yarn, for example, is used in artificial blood vessels, heart valves and sutures left in the body after internal surgery. Total annual sales for such uses are less than $200,000, a tiny fraction of 1 percent of the $9 billion market for such yarn in clothing, homes and industry, according to a recent study for the Health Industry Manufacturers Association.

A Drop in the Bucket

Another material being withdrawn from the implant market by Du Pont and Hoechst Celanese is polyacetal resin. The automotive, industrial, plumbing and consumer products sectors buy $1.3 billion of it annually, the implant industry buys just $50 pounds, valued at $5,300, for use in heart valves



The New York Times

Pelletrane, a polyurethane that Dow Chemical began pulling from the medical market in 1990, is used in products like automobile hoses and athletic shoes. The medical market is so small that Dow said it did not realize that companies like Medtronic Inc., the world's largest pacemaker manufacturer, used Pelletrane as a coating until three years after Dow acquired the business from the Upjohn Company in 1985.

In the past, companies like Du Pont have made products like Dacron polyester, Delrin polyacetal resin and Teflon polytetrafluoroethylene fiber

and resins available to medical companies accompanied by warnings that they had not been tested in any way to establish their suitability for medical applications.

"Everything is manufactured for industrial and consumer purposes," said Katherine Knox, the manager overseeing Du Pont's transition toward cutting off all such sales. "But for 30 years we had a policy that we wouldn't withhold materials from the medical sector because we didn't want to inhibit development."

That policy began to seem foolish after a start-up company in Houston, Vitek Inc., used Teflon to make a jaw

Big companies don't want any blame for misuse of their products.

implant. The device was used by oral surgeons in more than 25,000 patients in the 1980's to treat temporo-mandibular joint syndrome, which causes pain, clicking sounds in the jaw and restricted jaw movement.

Each Vitek implant used about 5 cents' worth of Teflon. Du Pont played no role in designing or selling the product. But when the implants began to fail, plaintiffs' lawyers, who anticipated that Vitek would soon be swamped by claims, often named Du Pont as a co-defendant.

The plaintiffs, who were seeking compensation for disfigurement, depression, chronic pain and spasms that interfered with activities like eating and talking, have argued that Du Pont knew or should have known that Teflon was unsuited for Vitek's implants and should have refused to supply it. So far, Du Pont has successfully defended all but one suit. It says it is confident of having that jury verdict thrown out on appeal, but its legal costs are running into tens of millions of dollars.

Du Pont told customers in January 1993 that it would stop supplying any materials to implant companies in a year's time. But complaints from customers about difficulties finding alternate suppliers quickly led the company to grant permission for the sale of an extra two years' supply.

Du Pont also agreed to evaluate case by case the problems of any company unable to find alternate supplies by then. Some may end up begging for more time.

"We've approached more than 15 polyester makers in the United States and Europe, but the best response we've had so far has been a few people willing to give us samples to test with no commitment to supply," said Dennis Genito, vice president of product surveillance at Medtox Medicels Inc., an Oakland, N.J., manufacturer of artificial blood vessels and other vascular grafts made of Du Pont's Dacron. "We are hoping to find an alternate and get it through the regulatory process in time, but I wouldn't say I'm optimistic."

Legal claims totaling billions of dollars have piled up involving faulty breast implants that used silicone made by Dow Corning, which has stopped supplying silicone rubber to most equipment companies.

Dow Corning made silicone breast implants and numerous other devices as well as raw materials for other companies. But as the suits multiplied, basic silicone suppliers with no other connections to the implants, like General Electric and Union Carbide, were also named as defendants.

Consumer advocates like Dr. Sidney Wolfe, the medical affairs spokesman for the Public Citizen Health Research Group, a Washington-based lobbying group, say the litigation is an inevitable result of misguided Federal laws and policies that have allowed most medical implants to reach the public without extensive testing and specific approval from the Food and Drug Administration. The basic law governing medical devices, passed in 1976, allowed equipment makers to market products and introduce new ones without lengthy Government reviews by submitting evidence that they were "substantially similar" to products already sold.

Dr. Wolfe said it made sense to have suppliers joined with the equipment makers in protecting consumers from what he sees as deficiencies in the 1976 act.

"If you sell something, you are in the chain of responsibility," Dr. Wolfe said. Eventually, he said, the lawsuits will lead to the use of better-quality materials in medical equipment.

Suppliers and equipment makers disagree, saying such a policy puts on unworkable burden on suppliers to be deeply involved in the details of customers' products and operations.

"How many questions can a supplier ask without getting into trade secrets?" said John Dames, a lawyer in Chicago with Kelley, Drye & Warren, whose clients include Union Carbide in the silicone breast-implant litigation. "Not many."

That is not the only problem. Unlike the situation in the drug industry, which is dominated by a few giants, two-thirds of the products developed in the medical equipment area typically come from small companies. Many buy such small amounts of materials that they do not deal directly with big suppliers, making it hard for suppliers to monitor how materials are used.

Some suppliers are willing to continue dealing with large customers that agree to pay for any litigation costs that might come up. Dow Corning, for example, still supplies silicone rubber for customers like Baxter International, the world's largest hospital supply company. But it now makes Baxter responsible for drawing up specifications for the silicone rubber. Most equipment makers are too small to produce a reliable indemnification agreement. They also lack the research expertise to develop materials' specifications efficiently without their suppliers' help.

In some cases, large, well-capitalized suppliers will probably be replaced by smaller operations that are less likely to be sued.

That seems to be happening in the silicone rubber market, where Dow Corning's customers are looking for silicone from the Applied Silicone Corporation and Newsil, two small Southern California companies.

"As far as I know, we are the only two left in the world," said Alastair Winn, chief executive of Applied Silicone, based in Ventura.

The CHAIRMAN. Ms. Wittkin.

Ms. WITTKIN. Thank you, Madam Chairman. I would like to thank you first of all for inviting me to testify about the malpractice liability and quality assurance program reforms in S. 454. These are issues of paramount importance to the safety and well-being of every American, yet this legislation has done an immense disservice to these issues through its gross distortion and misrepresentation of the medical malpractice problem.

To illustrate how and why this bill fails to provide adequate patient protection, fair victim compensation, or reduction in health care spending, I would like to address the malpractice issue from three perspective: the human toll, the disparity between malpractice myth and reality, and S. 454's proposed solutions to the malpractice epidemic in this country.

Medical malpractice is one of the leading public health epidemics crippling our Nation today. It is the third leading cause of preventable death, second only to those deaths associated with cigarette smoking and alcohol abuse. Every 6 minutes, medical malpractice claims the life of another human being in this country. It is appalling how ineffectual this and every other administration has been in dealing with a public health crisis of this magnitude and the agonizing plight of millions of its victims.

As a survivor of medical malpractice, I am left with a lifelong disability and a constantly painful reminder of what happens when the public is left unprotected from incompetent and dangerous doctors.

My case occurred in California and was tried under the Medical Insurance Compensation Reform Act, otherwise known as MICRA, so I am personally familiar with how cruel, dehumanizing and regressive that tort reform is. Yet it is the same anti-consumer act that provides the framework to S. 454, and for similar medical liability reform legislation which the Senate will be taking up this session.

As a patient advocate, most of my time is spent dealing with the flood of calls and letters that we receive from victims across the country who are desperately seeking help, answers, and I think above all, accountability.

Somehow, Congress must begin to understand that 100,000 deaths and 300,000 serious injuries caused by medical negligence each year are not just statistics. These are your neighbors, your friends, your families; they are your constituents, the people whom you were put here to represent and protect.

Much of the truth about malpractice to date has been eclipsed by the outrageous myths perpetuated by the medical industry. Let me give you some facts to dispel those myths and set the record straight.

Fact: We do not have too many malpractice suits in this country; we have too few. More than 90 percent of victims never bring suits.

Fact: Negligent doctors and hospitals already get a free ride on taxpayers' shoulders, who are forced to pay $60 billion a year to provide care and services to victims who are currently locked out of the tort system.

Fact: Almost 60 percent of indefensible cases are currently being won by defendant doctors in trials.

Fact: States that have already adopted reforms like those being discussed here today have failed to realize any of the so-called benefits proposed by this bill, such as increased access to care or reduction in health care spending. And according to a recent OTA report, the current liability system is not responsible for runaway defensive medicine spending in this country.

For some reason, though, these and many other facts contained in my written testimony have been completely ignored by the sponsors of S. 454. Instead, this legislation virtually annihilates the rights of medical consumers and malpractice victims.

For example, one-way preemption will further penalize malpractice victims who live in States which have already adopted more aggressive liability reforms than would exist under S. 454 by allowing those State laws to stand.

Increasing the burden of proof that victims must meet in obstetric delivery cases if a doctor has not treated a patient before will effectively guarantee immunity from liability for incompetent physicians.

Punitive damage awards are virtually nonexistent in medical malpractice cases, and this bill's plan to use a portion of this nonexistent award to fund a State health care quality assurance program will never address the incalculable human and financial toll malpractice takes.

The elimination of the collateral source rule will reduce the value of the case, will make it more difficult for victims to bring suits, and will create a hidden tax on both employers and taxpaying citizens in order to cover all of the collateral source benefits the medical industry will now be shielded from paying. Periodic payments of awards will significantly reduce the value of a case and let the wrongdoer get off cheaply by purchasing an annuity for a fraction of the victim's award.

But the most insidious aspect of S. 454 and its true objective is to railroad all malpractice victims into mandatory, binding alternative dispute resolution, effectively doing away with the civil justice system for malpractice victims. By forcing victims who choose to go to court to meet the same standard of proof against their doctor or hospital that applies in criminal proceedings, plus making them prove gross negligence or intentionally caused harm, you have in essence forced all victims and their families to settle claims outside of the tort system. It is highly unlikely that a victim will prevail in any of the proposed ADR programs, and if they do prevail, they must do so without benefit of adequate legal representation, discovery, or compensation for their injuries.

Further, the language in the ADR section opens the door for all States to do away with pain and suffering awards entirely. By requiring States to choose only one ADR mechanism, although they may adopt more, a State may adopt only the early offer and recovery option, in which case there is no recovery for pain and suffering. That would virtually decimate victims' rights.

Again, no one is going to argue that the tort system is not in need of dramatic reform, but we believe that S. 454 is not the solution.

Thank you.

The CHAIRMAN. Thank you very much, Ms. Wittkin.

[The prepared statement of Ms. Wittkin follows:]

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TESTIMONY OF LAURA WITTKIN, EXECUTIVE DIRECTOR
ON HEALTH CARE LIABILITY REFORM AND QUALITY ASSURANCE

Before the
COMMITTEE ON LABOR AND HUMAN RESOURCES
MARCH 28, 1995

Good morning, my name is Laura Wittkin. I am the Executive Director of the National Center for Patients' Rights, a medical malpractice victims' and patients' rights advocacy and support group. I am also a survivor of medical malpractice.

Thank you for inviting me to testify about the medical malpractice liability and quality assurance program reform proposals in Senate bill S. 454. These are issues of paramount importance to the safety and well-being of every American. Yet, these issues are done an immense disservice by this legislation's gross distortion and misrepresentation of the medical malpractice issue.

Medical malpractice is one of the leading public health epidemics crippling our nation today. It is the third leading cause of preventable death, second only to those deaths associated with cigarette smoking and alcohol abuse. Every six minutes medical malpractice claims the life of another human being in this country. It is appalling how ineffectual this and every other Administration has been in dealing with a public health crisis of this magnitude, and the agonizing plight of its millions of victims.

Thanks to the medical industry's longstanding, highly successful propaganda campaign, with its spurious characterization of malpractice victims as greedy parasites persecuting innocent doctors for financial gain, among other things -- the rights of its victims and medical consumers alike have been dealt a crushing blow.

If this Congress is truly interested in improving the quality and cost of health care in this country it must move beyond the political rhetoric of rich and powerful interest groups and rely upon the wealth of empirical studies which graphically portray an out-of-control, profit driven, medical system which promotes inferior and substandard care.

To illustrate how and why Senate bill S. 454 fails to provide adequate patient protection, fair compensation to victims of medical malpractice, or to reduce health care spending, I would like to address the liability reform issue from three perspectives:

1. The human toll of medical malpractice

2. The medical malpractice liability system: Myth vs. Reality

3. The proposed solutions to the growing malpractice epidemic outlined in Senate bill S. 454.

I. THE HUMAN TOLL OF MEDICAL MALPRACTICE:

As a victim of medical malpractice, I am left with a lifelong handicap and the constantly painful reminder of what happens when the public is left unprotected against incompetent and dangerous doctors.

My malpractice case was tried in California nine years ago under the Medical Injury Compensation Reform Act, otherwise known as MICRA. Under MICRA I experienced, firsthand, the cruel and dehumanizing effects of regressive tort reform which rewards the wrongdoer and punishes their victims by callously limiting their legal redress and compensation.

Unfortunately, it is this anti-consumer Act which provides the framework for Senate Bill S. 454, and for similar medical liability reform legislation, which the Senate will be taking up this Session.

My own life-threatening experience with medical malpractice led me to form the National Center for Patients' Rights (CPR), the largest advocacy and support group of its kind, where most of my day is spent responding to the overwhelming flood of calls and letters we receive from medical malpractice victims and their loved ones who are desperately crying out for help, answers, understanding, compassion, and above all, accountability.

The families that reach out to our organization are trying valiantly, though often unsuccessfully, to cope with the senseless loss of a child, the untimely death of a spouse or parent, permanent crippling injuries or unbearable pain and suffering, which rob victims of their dignity and quality of life, and often leave entire households shattered in their wake.

In the last month alone, there has been a rash of tragic medical malpractice cases making national headlines: Willie King, the 51 year old diabetic from Tampa, Florida whose surgeon amputated the wrong leg, and who has now, as a result, lost both of his legs; Leo Alfonso, the 77 year old man who died after being mistakenly disconnected from his respirator; Betsy Lehman, the 39 year old health columnist for the Boston Globe and mother of two young children ages three and seven, who died from a massive overdose of drugs during chemotherapy treatment for breast cancer; the 69 year old Michigan woman suffering from breast cancer who had the wrong breast removed; or little four year old Desiree Ward from New York City, who hemorrhaged to death after a routine tonsillectomy. These cases, however, merely represent the tip of an evergrowing iceberg.

Two weeks ago, I attended the funeral of my 29 year old friend Karin Smith from Wisconsin. Karin succumbed to metastasized cervical cancer that had gone undiagnosed by her HMO for three years despite her repeated complaints, numerous positive lab results and all of the classic clinical symptoms of cervical cancer.

For the last four years of her life, Karin was forced to endure the agonies of endless aggressive cancer therapies and surgeries, all of which were futile as a result the fatal delay in her original diagnosis.

Karin was a very courageous young woman who devoted the last three years of her life fighting for patients' rights. Last year, in fact, during the National Health Care Reform debate, Karin testified before Congress on two occasions, despite her increasingly frail condition.

Karin's story typifies the horrifying and heartbreaking human toll medical malpractice takes on all of us – not only on its victims, but on their loved ones, as well. Somehow Congress must begin to understand that the 100,000 deaths and 300,000 serious injuries caused by medical negligence each year aren't just statistics...they are your neighbors, your friends, your families...they are your constituents, the people who put you here to represent and protect them.

Congress must also understand that no doctor's liability anxiety can ever begin to compare to the real life pain and suffering endured by hundreds of thousands of medical malpractice victims and their families in this country each and every day.

II. MEDICAL MALPRACTICE MYTH VERSUS REALITY:

The MYTHS about the malpractice system, which have been carefully propagated by the medical industry and embraced by the proponents of Senate bill S. 454, are outrageous and baseless:

MYTH: The liability crisis and high premiums are responsible for decreased access to care, runaway health care spending, and defensive medicine practices.

MYTH: The medical malpractice liability system is overwhelmed by excessive and frivolous lawsuits.

MYTH: Lawsuits result in outrageous jury awards and excessive plaintiff attorney fees, and do not deter poor care.

Permit me to set the record straight with the following facts, which belie the medical industry lobby's "self-anointed" status as "victims" of the medical malpractice system:

FACT: The current medical malpractice system actually prevents the majority of victims (90%) from bringing lawsuits, and most victims who receive awards are undercompensated based on the severity of their injuries.

FACT: The liability system as it exists today, already gives negligent practitioners and providers a free ride on the backs of the American taxpayers. It's the taxpayers who foot the sixty billion dollar bill each year to provide care and services to the hundreds of thousands of victims who have been locked out of the legal system. According to Dr. Troyen Brennan, co-author of the landmark Harvard Medical Practice Study, "this figure of $60 billion is larger than the combined estimates of the costs of medical malpractice premiums ($10 billion) and defensive medicine ($10-$20 billion)".

FACT: Individual states which have adopted tort reforms similar to ones outlined in S. 454, have failed to realize any of the so-called benefits proponents of this legislation claim, such as: savings to the health care system, increased access to health care, more affordable care, or a reduction in "so-called" defensive medicine spending and "frivolous" lawsuits by plaintiffs.

FACT: The malpractice liability system is not responsible for runaway "defensive medicine" practices. The recent study on Defensive Medicine and Medical Malpractice, by the Office of Technology Assessment (OTA) found that both the AMA and Lewin Studies on defensive medicine spending are inaccurate, unreliable and not based on empirically solid evidence. (Yet, these defensive

medicine studies are still used as one of the primary justifications for national liability reform.)

OTA also found that physicians rarely perform tests that will not benefit patients, and that much of what is mistakenly characterized as "defensive medicine" practices is, in fact, sound medical practice. OTA concluded that while tort reform may lower premiums and a physician's anxiety, it will not effect the practice of defensive medicine.

These findings were echoed in an earlier Congressional Budget Office Report on Health Care Reform, which stated that even if medical malpractice liability were reformed, "much of the care that is commonly dubbed "defensive medicine" would probably continue to be provided for reasons other than concerns about malpractice."

FACT: Victims of malpractice are forced to wait years for redress and compensation while insurance companies and defense attorneys, driven by their own financial self-interests, syphon off their profits through investment earnings and uncapped and outrageously high hourly defense fees for handling such cases -- All of which are responsible for driving up the cost of the medical liability system.

FACT: The malpractice system is not at all biased against doctors, but is, in fact, remarkably lenient towards them. It is a system in which doctors do not lose malpractice cases they should win. And it is a system whose payouts to victims are not based on the whims of overly sympathetic jurors, but rather are consist with the extent of negligence and injury to the patient. (These findings based on the 1992 American College of Physicians Study on medical malpractice lawsuits of New Jersey).

FACT: Successful frivolous defenses by doctors, lawyers and insurance companies FAR OUTNUMBER "possible" frivolous plaintiff's verdicts by a staggering ratio of 12 to 1 according to a landmark study by the American College of Physicians, published in the Annals of Internal Medicine, November 1992. The study found that doctors currently win approximately 60% of indefensible cases at trial, compared to as few as 5% plaintiff wins in so-called defensible cases.

FACT: The tort system DOES deter poor practices. According to Dr. Troy Brennan of the Harvard Study team, recent empirical analysis done at the hospital level found that as liability claims increased per 1,000 discharges, the risk of negligent injury for patients decreased. To quote Dr. Brennan, " this is the first statistically significant evidence that there is a deterrent effect associated with malpractice litigation. It suggests that tort litigation, with all of its warts, nonetheless accomplishes the task for which it is primarily intended, that is the prevention of medical injury".

III. PROPONENTS OF SENATE BILL S. 454 RESPONSE TO THE MEDICAL MALPRACTICE EPIDEMIC:

Proponents of Senate bill S. 454 claim that the purpose of this legislation is to:

1. Ensure that victims with meritorious cases receive fair and adequate compensation, including reasonable non-economic damages.

2. Increase access to health care in areas which are underserved as a result of liability actions.

3. Improve the fairness and cost-effectiveness of our current health care liability system to resolve disputes and provide compensation in liability cases.

4. Improve health care quality through the establishment of State quality assurance programs.

Under this bill however, NONE of these "so-called" goals can and will be met. Instead, this legislation virtually annihilates a patients' recourse in the tort system; cripplingly reduces financial resources available to deal with the harmful effects of medical negligence; does nothing, whatsoever, to ensure increased access to health care in underserved areas; and fails to provide any quality assurance program to reduce the epidemic of medical malpractice in this country. The one thing this legislation will do, however, is allow negligent doctors and hospitals to sleep better at night.

While we oppose Senate Bill S.454 in its entirety, SEVERAL of the proposals outlined in the bill are particularly troubling:

1. One Way Preemption:

   Federal Preemption should create a level playing field for all Americans. One way preemption, however, further penalizes malpractice victims who live in states which have already adopted even more regressive, anti-consumer malpractice liability laws than would exist under S. 454.

2. Obstetric Case Burden of Proof:

   This proposal would effectively shield all negligent and incompetent obstetricians from medical liability if they commit malpractice on a patient they have not previously treated. By significantly increasing the burden of proof that victims and their families would be required to meet in those situations (which occur more often than not, particularly for indigent and minority women), these negligent doctors will be effectively guaranteed immunity from liability.

3. **Cap on Punitive Damage Awards:**

Punitive damage awards are virtually nonexistent in medical malpractice cases. If they do occur, most cases involve the sexual abuse of a patient, which is in essence a criminal act. In those cases where awards are made, however, punitive damages do serve to protect consumers by deterring unconscionable and outrageous physician misconduct. Capping these awards at $250,000 not only rewards those doctors who commit these heinous acts of misconduct, but dangerously diminishes the important deterrent effect of these awards.

The fact that it is also the intention of this legislation to fund state quality assurance programs using a portion of these virtually non-existent awards, (creating yet another unfunded federally mandated program), only serves to drive home the point that proponents of this legislation DO NOT CARE about the incalculable human and financial toll medical negligence is taking on the citizens of this country.

4. **Elimination of Collateral Source Rule:**

This reform requires that all victims' awards be **automatically reduced** by any past or future health care, social service, employment or other benefits they may be eligible for. However, there is no way to guarantee that all of a victim's medical needs will be met by their specific health care plan, or that they will, automatically, in the future qualify for and receive other collateral benefits. Also, reducing an award by collateral sources instead of allowing for subrogation, significantly devalues a case, making it a less economically viable case for prospective attorneys. The net result of this proposal is the further victimization of patients harmed by substandard care.

Using what is essentially a "bait and switch" scheme on the American people, which would put more money back into the pockets of wealthy insurance companies and negligent doctors and hospitals, this proposal will shift much of the financial burden of caring for malpractice victims from the wrongdoer to the taxpayers.

It will place a hidden health care tax of untold billions of dollars each year on employers and taxpaying citizens in order to cover all of the collateral source benefits the medical industry would now be shielded from paying. **This hidden tax would be in addition to the $60 billion a year taxpayers are currently footing to care for those medical malpractice victims who are denied access to the legal system.**

5. **Periodic Payment of Awards:**

This reform states that, instead of paying out the entire award upfront, the award will be paid out over a period of many years or a victim's lifetime. This proposal is just one more example of the cruel re-victimization of patients harmed by poor care.

It will allow the wrongdoer to purchase an annuity for a fraction of the cost of the award (about 1/3 the cost), to invest much of that money, only to dole it out to the victim bit-by-bit over the course of the victim's lifetime.

This effectively shackles malpractice victims and their families to an endless bureaucratic system and deprives them of their just compensation. And, if the victim dies BEFORE all of the award is paid out, the unpaid medical and economic losses go back into insurance company coffers, NOT to the victim's family.

Periodic payments also dramatically reduce the overall value of a case, again, creating an enormous financial disincentive for an attorney to take those cases on.

6. **Alternative Dispute Resolution Mechanisms (ADR):**

The most insidious aspect of Senate bill S. 454, and its true PRIMARY OBJECTIVE, is to railroad all malpractice victims into MANDATORY/BINDING ADR -- effectively doing away with the civil justice system for all medical malpractice cases.

Under this proposal, victims and their families would be forced to settle their claims outside of the court system. If they prevail at all, they would do so without the benefit of adequate legal representation, discovery, or compensation for their injuries and harm due to negligence. It is highly UNLIKELY, however, that victims would prevail under the ADR system proposed.

Although none of the ADR systems outlined in the bill are BINDING per se, the language in the legislation, nonetheless, forecloses on a victim's right to a trial by forcing victims and their families to meet the same standard of proof, "proof beyond a reasonable doubt", which must be met in all criminal proceedings in this country.

With the level of defendant fraud, perjury and destruction of evidence, already so prevalent in medical malpractice defense cases -- coupled with the fact that we know, based on the landmark study by the American College of Physicians, that defendant doctors are already winning 60% of INDEFENSIBLE cases at trial under the current lower standard of proof – it would be criminal to impose an even higher standard of proof.

By applying this outrageous and unrealistic standard, proponents of this legislation will make these cases virtually untriable for civil plaintiff attorneys. If plaintiffs must meet the same standard of proof as required in a criminal case, then it is only fair that all defendant doctors and hospitals found guilty, be subject to the same penalties which apply under criminal law: imprisonment, loss of license, fines, loss of property, or even the death penalty, where applicable.

Further, the language in the ADR section opens the door for all states to do away with pain and suffering awards entirely. By requiring that states choose only one ADR mechanism (although they may adopt more if they wish), any state which adopts only the EARLY OFFER AND RECOVERY ADR option, in which there is no recovery for pain and suffering, would decimate victims' rights entirely.

CONCLUSION:

No one will argue that the medical malpractice liability system is in need of dramatic reform to better serve both medical consumers and victims alike. Senate bill S. 454, however, does nothing but serve up our rights on a silver platter, to the politically powerful insurance and medical industry. On behalf of your constituents, I urge you to oppose S. 454.

(A LIST OF RECOMMENDATIONS IS ATTACHED)

FEDERAL PRO-CONSUMER MEDICAL MALPRACTICE LIABILITY REFORM RECOMMENDATIONS:

To improve the malpractice liability system and protect the rights of medical consumers and victims of malpractice, the National Center for Patients' Rights recommends the following:

(NOTE: Where applicable, these reforms are intended to preempt state law.)

1. A three-year statute of limitations for the DISPOSITION of all malpractice cases (from date of filing).

2. Expedited handling of cases involving children and terminally ill patients.

3. Creation of a Small Claims Binding Arbitration Unit for cases under $100,000.

4. A cap on defense attorney fees.

5. Removal of limitations or caps on non-economic damage awards.

6. Full, lump sum payment of awards, unless otherwise requested by the plaintiff.

7. Reinstatement of the collateral source rule, along with the right to subrogation in all states which have eliminated that rule.

8. Opening the National Practitioners' Data Bank to the public, in its entirety. And creating an on-line inquiry system to allow easy access for consumers.

9. Closing the reporting loopholes in the National Practitioners Data Bank which currently allow doctors to remove their names from malpractice case settlements involving hospitals and managed care plans.

10. Outlawing secrecy agreements.

11. Mandating medical malpractice insurance coverage, (the minimum amount of coverage, to be determined) as a condition of licensure for all physicians.

12. Community-rating of malpractice premiums so that the costs are spread more equitably among the specialties.

13. A minimum 3 1/2 year statute of limitation for filing malpractice lawsuits. That statute would be extended in cases where there has been continuous treatment, late discovery, suppression of information or criminal coverup. (This statute would not apply to minors.)

14. Mandatory audits for all medical malpractice insurance carriers (once every three years) so that premium rates can be appropriately adjusted. These audits would also be required PRIOR to any state granting premium increase requests.

15. Federal minimum standards for all State Medical Boards (see attached Federal Model prepared by CPR.)

MODEL FOR STATE MEDICAL BOARD MINIMUM STANDARDS

In order to improve physican discipline and protect the public from harm, the Federal government should enact the following minimum requirements for all state medical boards (in alphabetical order):

1. **Board Composition:**
All Boards shall be comprised of a majority of public members (at least 51%, preferably two-thirds). The Chairperson and Vice-Chair of the Board shall be public members. The size of the Board shall be based on the state's physician population (to be determined). Physician Board members shall be appointed by the Governor based solely on recommendations not nominations from a variety of recognized medical and non-medical

sources (to be determined). Board members shall serve a term of no longer than 3 years (with one consecutive term).

2. **Consent Agreements:**
Boards shall prohibit plea bargins or consent agreements unless the physician agrees to plead guilty to the most serious allegation. Boards shall prohibit such agreements in negligence and incompetence-related cases unless the physician agrees to plead guilty to the most serious allegation and surrender his or her license.

3. **Consumer Protection Unit:**
Boards shall create a special Consumer Protection Unit which will consist of consumer protection officers with medical or social work background to deal directly with victim complainants. And all victim complainants shall be granted statutory immunity from liability, for libel, defamation, etc.

4. **Disciplinary Hearings:**
Board disciplinary hearings shall be open to the public, and all hearings shall adhere to a specified time frame (to be determined).

5. **Funding:**
Boards shall be allotted adequate funding in order hire the caliber of investigators, prosecutors and support staff necessary to effectively oversee the profession (and may raise physician fees to do so). All physician licensure and registration fees, and any reserves, shall be dedicated for exclusive use by the medical board. These funds may not be touched by a state for ANY reason other than the prescribed ones.

6. **Impaired Physicians:**
Boards shall establish an Impaired Physician Program (based on a model to be developed), and shall maintain jurisdiction over that program. Boards shall conduct an annual audit of the Impaired Physician Program and make the findings publicly available.

7. **Informal Actions:**
Boards shall share information about informal actions, such as letters of warning, with other jurisdictions.

8. **Investigators:**
Boards shall upgrade the salary and qualifications for complaint investigators (2/3's of whom shall have medical background).

9. **Licensure:**
Boards shall be responsible for both licensure and discipline of physicians.
Grounds for denial of licensure shall include the following:

   a. Any act or conduct which would constitute grounds for medical misconduct in the state in which the physican is applying.

   b. Any disciplinary action taken in another jurisdiction, which would constitute grounds for medical misconduct in the state in which the physician is applying.

   c. Any PENDING disciplinary investigation or action in another jurisdiction.

   d. Loss of hospital privileges in another jurisdiction.

   e. Malpractice lawsuits in another jurisdiction indicating that the doctor presents a risk.

10. **License Restorations:**
Boards shall require that any physician who has lost a license (as a result of surrender or revocation), wait a minimum of 5 years before applying for reinstatement of license, and must provide proof of on-going medical and remedial training (the parameters for which are to be determined).

11. **Malpractice Insurance:**
Boards shall require doctors to carry malpractice insurance as a condition of licensure. The amount of coverage shall be determined by the specialty. Physicians who perform surgery, but DO NOT have hospital privileges shall carry the same minimum coverage as physicians with hospital privileges.

12. **Malpractice Data Unit:**
Boards shall create a Malpractice Data Unit. This unit will be responsible for collecting all malpractice data statewide, and reviewing all malpractice claims to determine if they warrant further investigation for possible medical misconduct. This unit will also be responsible for developing a system that will flag physicians with an abnormally high number of malpractice claims or payouts. Doctors who fit these "outlier" profiles (which should be based on the size and scope of a doctor's practice, the specialty, and other risk-adjusted factors) would be subject to an automatic full-scale investigation.

13. **Mandatory Reporting:**
Boards shall require mandatory reporting of violations or dangerous practices by all licensees (including self-reporting by the licensee committing violation), courts, hospitals (staff and administration), all other health care providers (including HMO's clinics, etc.), liability insurance carriers, state and local medical societies and associations, state and local professional societies, other state agencies, PRO's, other health care professions, and federal agencies. All states shall impose severe civil penalties for failure to report.

Boards shall assure confidentiality to those reporting to the Board in good faith on possible violations. Board members, Board staff, individuals, and organizations required by law to report shall be granted immunity from prosecution and suit.

Liability carriers and self-insured entities must report all claims, and all payments including the dollar amount.

14. **Misconduct Definitions:**
Boards shall adopt uniform definitions of medical misconduct (based on a compilation of the strongest current state medical misconduct definitions).

15. **Out-of-State Actions:**
Boards shall not conduct a new hearing on any action taken by another jurisdiction, but shall only determine the appropriate disciplinary sanction to be imposed based on that out-of-state action. That sanction shall, at a minimum, be equivalent to the original sanction imposed.

16. **Permanent Loss of License:**
Boards shall permanently revoke the license of any physician convicted of medicaid/medicare fraud, fraudulent billing, child sex abuse, other sex abuse, murder (and other criminal acts, to be determined); or found guilty of falsifying or, in any way, altering medical records to conceal malpractice or other wrongdoing.

17. **Physician Discipline Oversight Panel:**
Boards shall establish a Discipline Oversight Panel to assess the physician discipline system. The panel shall consist of seven members appointed by the governor and may include no more than two physicians and one attorney.

(17. continued)

The panel members shall serve as individuals not as representatives of any organization, institution, agency or group. Panel members shall not participate in or review pending matters, but will review final determinations to assess the quality of work and whether the decisions are in the public interest. The panel shall assess the overall goals and objectives of physician discipline; how well the goal are being met; and whether and to what degree the process serves to minimize or deter medical misconduct. The panel may consult with medical and specialty societies, consumer organizations, other governmental organizations, state organizations, federal organizations and other states in its analysis and deliberations.

This panel shall also handle complainant appeals of cases dismissed by the Board without action.

18. **Physician self-referrals:**
Boards shall prohibit the practice which allows treating doctors to refer patients to clinics, labs, or other health care-related facilities or services in which that doctor, or his or her immediate family, has a financial interest. Any violation shall constitute grounds for medical misconduct. Any physician who currently self-refers shall have one year to comply with the statute.

19. **Public Information and Outreach:**
Boards shall have a public information officer responsible for organizing consumer and physician outreach and education programs, to include: development of a quarterly newsletter, information brochures, public serve announcements, and other outreach efforts to community groups, organizations, agencies, etc.

Boards shall set-up (and adequately staff) toll-free hotlines for consumer complaints and physician background checks. Anyone calling to check on a doctor shall automatically be entitled to the following physician "profile" information: date physician was first licensed; educational background; registration status; hospital affiliations; other states in which the doctor holds a license; the number of closed complaints against the physician (regardless of whether or not an action was taken); any formal charges pending against the physician; any disciplinary action taken against the physician's license (including a brief explanation about the basis for the action). This profile may be mailed to consumers upon request. After the federal government enacts legislation to open up the National Practitioners' Data Bank, callers will also automatically be given the Data Bank's toll-free number.

Boards shall issue an annual report made available to the public, media, legislature and other state officials. The report should contain information on licensure, including: # of applications received, licenses granted, licensure hearings, denials, temporary licenses, etc.

19. continued)

The report shall also contain disciplinary information, including: # of complaints received (plus the source, status, category), # of actions taken, category of action; types of penalties; aggregate information about informal actions taken, etc. (Full list of items, to be developed.)

20. **Recredentialing:**

Boards shall require doctors to be recredentialed every 5 years as a condition of licensure. Doctors who have been involved in lawsuits or other disciplinary actions during any interim period, would be required to undergo a "clinical" performance evaluation as part of their recredentialing.

Doctors who practice exclusively in private office settings would also be required to undergo clinical performance evaluations and patient chart reviews for recredentialing.

21. **Standard of Proof:**

Boards shall require that the standard of proof in disciplinary actions be a preponderance of the evidence ONLY. No other standard will be acceptable.

22. **Subpoena Power:**

Boards shall have full subpoena power.

23. **Summary Suspensions:**

Boards shall have the power to issue summary suspensions which will run until a hearing can be promptly scheduled.

The CHAIRMAN. Let me begin with some questions, and I know other Senators have many questions.

On the cap on damages, Dr. Dickey, as you noted, S. 454 does not cap noneconomic damages such as pain and suffering or inconvenience, mental anguish, loss of enjoyment of life; it does not cap those, and you are making the case for capping those damages, as Senator Coats did earlier.

But I would like to ask all the panelists if the committee were to place a cap on noneconomic damages, would this unfairly prevent full recovery for victims? Could you give an example of the types of damages that plaintiffs would be able to recover?

Dr. Dickey, would you like to start?

Dr. DICKEY. I would be happy to start, Senator. I think it is important to recognize that a cap on noneconomic damages would not limit the ability of plaintiffs to be fully reimbursed for economic losses, so that future earnings, loss of ability to continue to earn a living in the way they have, as well as the anticipated future costs of whatever health care costs might be anticipated from the bad outcomes, are unlimited completely. And in fact, if we look at the examples in California where there have been particularly bad injuries, the plaintiffs have continued to be able to get multimillion-dollar awards to try to address those economic losses.

The noneconomic losses on the other hand are as best the system can attempt to acknowledge that a wrong has been done and to try to recompense things that, frankly, usually cannot be given back in the form of dollars. And when there is no limit on that noneconomic loss, then it becomes a lottery mentality, and unfortunately, most of those, as we have heard, do not go to the patient, but instead go to the system. They do not even recompense the individual who is the loser in the health care system.

The CHAIRMAN. Did you have a further comment, Mr. Scully?

Mr. SCULLY. Yes, Madam Chair. We support noneconomic damages caps, and I think the best evidence of the fact that they are not going to impose any undue hardship is that, for instance, there are 15 States that have noneconomic damages caps of below $500,000 already. Illinois, Maryland, Massachusetts, and Missouri, among members of the committee, already have noneconomic damages caps in their States of $500,000 or less.

Clearly, as Nancy said, the economic damages are not capped. As Senator Lieberman said earlier, punitive damages are only limited to three times economic damages, not just the $250,000 cap.

So we are happy to work with the committee to find a reasonable level that is acceptable to the Senate of what the economic cap level is. We think $250,000 is the right number. If it is somewhat higher than that, we are willing to work with you, and I know it is not in your bill right now, but we think there should be some cap.

The CHAIRMAN. Well, there is, of course, a cap on punitive damages——

Ms. WITTKIN. May I?

The CHAIRMAN. Yes.

Ms. WITTKIN. I would like to respond to the cap on noneconomic damages as well. First of all, I think it is very unfair to assume that everybody has extraordinary economic losses. There are many

of us out there who do not have jobs, who are indigent, who are retired, who may be homemakers, and we are not in a position where we would experience extraordinary economic losses.

The way the tort reform system is set up, it continues to shave away at the amount of compensation a victim gets, so it is really quite deceiving. Economic losses are not capped, but if somebody does not earn a living or they are at a very low-wage job, they are not going to get high compensable losses.

In addition to that, with periodic payments, you are talking about literally doling out, little by little, money to a victim over the course of that victim's lifetime. It is not the kind of award that makes a victim whole.

What happens when malpractice victims, the most severely injured of those victims, have not had economic losses, have collateral source reimbursements—they have health care insurance, so their award is reduced by that amount. They do not have the economic losses, so their award is reduced by that amount. But they are sitting home, they are in excruciating pain, they spend their lives in and out of hospitals, their marriages have fallen apart, their children are neglected.

How does a $250,000 cap compensate for the loss of quality and dignity and humanity of that person's life, and what kind of message do you send to doctors and hospitals who continue—continue—to provide negligent and substandard care, with complete immunity?

The CHAIRMAN. Well, you are making the argument against capping noneconomic damages——

Ms. WITTKIN. Yes, I am, Senator.

The Chairman [continuing]. Which of course, we do not do in this bill.

Ms. WITTKIN. You do not, but there is the potential, based on some of the language in this bill, to do away with noneconomic damages entirely.

The CHAIRMAN. Well, we have heard the case being made for it. I just want to point out that it is not in the language of the bill right now, of course.

Ms. WITTKIN. It is not in the language, and again, capping should certainly not be, because what you are going to do is really end up hurting those people who have been most severely injured by medical negligence.

The CHAIRMAN. Well, my time is up, but in capping punitive damages, I guess I would just wonder if you would take into consideration whether that cap actually provides deterrence for any medical malpractice.

Dr. DICKEY. If I may—and I realize your time is short, Senator—I think that first we have to recognize, as has been said, that punitive damages are rarely visited in a medical malpractice case because most of these are bad outcomes as opposed to intentional bad actions.

I think that we would be willing to work with the committee if it is felt that in those rare cases where someone was proven to be so far beyond the pale of normal practice that they did things intentionally or egregiously outside the realm of practice, if a higher cap on punitive damages were felt to be effective, we would be will-

ing to work with you. But I would remind you that the cases that have hit the headlines over the last few days as this subject comes up all occurred in an unlimited environment that, while the threat of malpractice cases certainly puts a pall on the doctor-patient relationship and many things we do, because they are not intentional, the threat of bigger punitive damages is unlikely to change the cases that are out there, because they are not intentional or thought out ahead of time; they are simply the result of human error.

The CHAIRMAN. Thank you.

Senator Kennedy.

Senator KENNEDY. Thank you very much.

Dr. Dickey, what are the States doing and what is the AMA doing with regard to licensing procedures, to go after those who have committed malpractice in these States? I would have appreciated some statements or comments about trying to get at the root causes of these problems. Can you tell us now how many people are losing their licenses in various States because of malpractice? How is the profession policing itself?

Dr. DICKEY. Well, Senator, we wish you would give us the opportunity to police ourselves better. We have so many restrictions that even systems that worked in the past are not available.

Senator KENNEDY. Well, would you let us know? would you submit them?

Dr. DICKEY. Absolutely.

Senator KENNEDY. Good.

Dr. DICKEY. We will get to you in writing some proposals.

Senator KENNEDY. Good.

Dr. DICKEY. Your implication is probably right. The State licensing boards do remove licenses of only a limited number of individuals. A good part of that is the legislative due process that is given so that even as an individual is investigated, it can take years to take away a license.

Second, again, most malpractice cases and most litigation is not because someone was drunk or high on drugs or totally incompetent for what they did, but because of the tremendous complexity of health care and the opportunity for human error.

The medical associations of this country do have an extremely complicated set of quality assurance and improvement processes, which frankly do not work as well as they might because if we were to open up every possible error and ask how did that happen, and what process can we put in place to keep it from happening, it would open up the possibility of lawsuit. So we find that physicians, nurses and hospitals to some degree draw more of a curtain around than they should because of the atmosphere in liability today.

Senator KENNEDY. Well, I would think you would have a lot more credibility if you came up here and told us what you are doing about the problems of malpractice. I have not heard you mention the problems that are out there, and how concerned you are about it. You know——

Dr. DICKEY. Senator——

Senator Kennedy [continuing]. Just a second, now. You are up here now, speaking for the American Medical Association about is-

sues of malpractice that are affecting hundreds of thousands of our fellow citizens in my State and States around the country and how we are going to try to deal with those issues. And we have heard, quite frankly, a very technical presentation about insurance. And I know I am not the only one up here, but I would have thought that as the principal spokesperson for the medical societies, that you would have included some comment about what is happening out there in terms of the tragedy of malpractice, what have been the trend lines, the steps that the AMA has taken to make a difference in terms of quality health care, and how you are getting a handle on this. Instead, the AMA is just saying we cannot wait until this act passes so that we can get lower insurance premiums. Meanwhile, we are finding that the profits in malpractice insurance companies are going right through the roof, and the premiums that are being paid by doctors are going down, and the total number of cases are going down.

Maybe I am the only one who questions this, but I would be glad to hear from you on it. I do not want to use all my time.

We have a variety of very important issues here, Madam Chairman. We are talking about changing the burden of proof in malpractice cases to a criminal standard; we are talking about joint and several liability, and other matters, and we get 5 minutes to talk about these matters, which are very, very fundamental in terms of protecting consumers. I am glad to do the best I can in terms of the 5-minute rule, but on matters that are as important as health care, I hope we can at least have a chance to hear from our witnesses.

Yes, Dr. Dickey?

Dr. DICKEY. Senator, if I may, first of all, I wish I shared your data, because our evidence is that liability premiums are again going up—they went up 14 percent last year in Maryland across the board. So the premiums are going up, and that cost is shared by patients as well as physicians.

Sixty percent of companies that provide liability insurance to physicians are not-for-profit. So that 40 percent that have profits must be doing remarkably well; it is not the majority that is impacted at all.

Let us talk about the real issue. Every physician out there hurts when there is a case where a patient has been wronged, where there has been an error, a bad outcome or, worse yet, gross negligence. And we share with great compassion the need to improve those places where there has been bad medical care.

I serve as a commissioner on the Joint Commission of Accreditation on Hospitals, which spends limitless hours of physicians and hospital administrators in this country, trying to be sure that processes do not allow human error to damage patients in any fashion. We spend hours on informatics that help us use the technology of computers today to make sure that there is not an oversight, a way to overlook a dosage or a process to help patients.

But because health care is ultimately delivered by human beings, while we want to approach perfection, Senator Kennedy, we may never get there, and the best we can do is be sure that the system of liability quickly and fairly recompenses the patient, identifies the people who are truly negligent and ought to be removed from

the system, but each and every liability case out there is generally an indication of a bad outcome, not necessarily of an incompetent physician.

Senator KENNEDY. Well, I want to hear from Ms. Wittkin, but I want just to repeat what "Business Insurance" had to say, Dr. Dickey—and maybe this is not authoritative, but it is an important document—"despite rapidly changing health care delivery, the prices of professional malpractice and professional liability for health remain stable. Most hospitals' health care systems will renew their liability in 1994 in part because of a decrease in claims severity and frequency."

Ms. Wittkin, could you please tell us about your own personal experience?

Ms. WITTKIN. Certainly. I had moved out to California about 14 years ago. I was a newlywed, sort of on the yuppie track. I was a headhunter, doing very well.

I had gone to my oral surgeon because I needed a tooth extracted. The result was 2 months of misdiagnosis and mistreatment, the culmination of which was a surgical procedure to extract two teeth and remove some bone around the teeth to see whether or not I was having a recurrence of a medical condition which I do suffer from.

They were going to do the procedure in the office; they decided at the last moment to do it in the hospital. I signed my consent form. My husband was there with me. The surgery was to take an hour. I was to miss a day of work.

When I woke up, I learned that they had in essence done radical surgery on me. They had done something called a partial maxillectomy. They had removed half of my palate, all of the teeth on that side, the ridge the palate sits on, the sinus, much of the cheekbone, and gone all the way up to the orbit of my eye. They had done so because they thought they were looking at a malignancy. And they had no way to close me, so they ended up taking the inside of my cheek and flapping it over to the midline of my palate, leaving me grossly deformed.

Needless to say, when the pathology results came back, there was nothing but inflammatory tissue there. There was no basis, no reason on this earth, for that surgery to have been done and to have certainly been done without informed consent, without talking to my husband, without waking me up.

It is those kinds of things that change—excuse me. [Pause.] It is those kinds of things that change how you see life. And when I hear Dr. Dickey describing the restrictions placed on doctors to police themselves, it is absurd. The reason we have such rampant medical negligence in this country is because doctors do police themselves. They run all the State medical boards. They have enormous power in the Federal peer review organizations. They have risk management, quality assurance programs. They literally run every physician oversight mechanism we have in this country, and they do a miserable job at it.

Doctors absolutely will not police themselves. We are not talking about a doctor who makes a mistake. Everybody makes a mistake. I use doctors. I have a continuing medical problem. I use doctors all the time, and I use doctors who have been sued in malpractice

cases, because I understand that people are fallible and do make mistakes.

But what we are really talking about here is those doctors who time and time again have committed egregious medical negligence. We have doctors with dozens of suits in Massachusetts who have been kicked out of hospitals, who have moved around from State to State, with hundreds of suits; in New York, who have been kicked out of New York, moved to Massachusetts, moved to New Hampshire, moved to California—unstoppable.

And on the other side of the equation, we have a medical industry preventing the public from gaining access to information that would at least allow us to make better informed decisions about our lives. If the medical profession refuses to police itself, then it should open up the National Practitioner Data Bank, it should reveal every action taken against a doctor by a hospital, it should begin to release mortality and morbidity data so that we know how often a doctor does a procedure and how well that doctor does the procedure—and the same thing for a hospital.

But the profession has been immune from any kind of oversight, and that is why you have a malpractice epidemic. You do not have it because there are people like me who feel like suing. Believe me, if I could change what happened to me, I would. I cannot. I think it is really important, though, to try to prevent it.

Senator KENNEDY. Thank you very much.

The CHAIRMAN. Thank you.

Ms. Wittkin, that was a very moving account, and it certainly does help to personalize the problem. You know, our bill does require that information be public, available, on all the disciplinary actions that have been taken. I think, actually, Dr. Dickey, you perhaps raised the point that you felt that was not important, but I would guess even the AMA would welcome that, because I think we do need that availability of information.

Ms. WITTKIN. Senator, the one problem, though, is that over 85 percent of the information stored by the National Practitioner Data Bank is medical malpractice payout information. Since State medical boards virtually never discipline doctors, particularly for medical malpractice—I think fewer than 300 are disciplined each year, and most of them are still practicing, so you are talking about nothing. Even though we have 6,000 hospitals across this country and 600,000 doctors, fewer than I think 700 or 750 doctors are disciplined by hospitals each year; only a fraction of those have to do with medical malpractice issues.

So there is very little data in the National Practitioner Data Bank that is of use to consumers without the medical malpractice payout information.

What we are talking about is creating a profile. We are not talking about just looking at malpractice and making a decision about that, or just looking at whether a doctor has been disciplined or not. You are giving people a false sense of security. If they look into the data bank, and they do not find that the doctor has been disciplined by a State medical board or disciplined by a hospital, they will think the doctor is great—and yet that doctor may have 50, 60, 70 suits against him, or 5 or 10, whatever it is. But what we are talking about is getting the information out there, making certain

that people get as full a picture, as many pieces of the puzzle as we possibly can.

You can find out about your cereal, you can find out about your car, you can check about your VCR—but we cannot find out about our doctors and hospitals. That has to change.

Mr. SCULLY. Can I respond very briefly, Senator?

The CHAIRMAN. Mr. Scully.

Mr. SCULLY. I obviously do not disagree with an obviously terrible situation. But I think the reality is that hospitals, for instance, get much, much larger awards generally than physicians do because they are depersonalized, large institutions, they are easier to sue, and they are easy to get big awards from.

I do not think anybody—we have lots of malpractice that is legitimate, and there is no question that you need to compensate those patients. The issue here is how is it treated in different States. I do not think the example here in California would be treated any differently in any of these States if you went through the caps that we advocate or the provisions in your bill.

Nobody is questioning that victims of malpractice need to be compensated adequately; they absolutely, positively do. The question is how do you do it under reasonable guidelines, and the issue is who is paying for it. We are all paying for it sooner or later, and it is completely out of control. And I think if you look at the States that have caps like this now, the problems which you argue about physician policing are no different. There is absolutely no evidence of any difference in levels of malpractice in the States that have these provisions versus the ones that do not.

The CHAIRMAN. Thank you.

Senator DeWine.

Senator DEWINE. Dr. Dickey, could you briefly respond to Ms. Wittkin's comments at the end of her testimony in regard to her suggestions? Do you have any problem with those suggestions as far as——

Dr. DICKEY. I am sorry. We have talked about a number of things.

Senator DEWINE. Basically, the thrust of the latter part of her testimony was, if I understood it correctly, information, more information being available, and as she points out, going beyond just malpractice decisions that have been made, or judgments, or actual discipline that has been taken, but trying to get some statistics.

Dr. DICKEY. Senator, it is my understanding that information such as having been disciplined or sent off of a hospital staff or losing your license is in the public domain.

The American Medical Association is thus far opposed to opening the National Practitioner Data Bank because so much of the data there is, number one, not verified data, and number two, can in itself be misleading. Because this is an issue I have talked about a number of times on behalf of physicians, I went to the trouble of trying to write and find out what was in the data bank on me, and when I finally got my answer from them, what I got was a sheaf of papers, a good 3 or 4 hours' worth of paperwork to fill out just to find out what was in the data bank on me. Henceforth, I have not done it, and I cannot even tell you whether there is anything or whether it is correct and verifiable.

If that information is not verifiable data and is yet handed out willy-nilly, we may do as much damage as we do good.

The AMA, though, is in favor of patients having information. We are involved in a number of things to try to make sure patients can get information about success rates, number of procedures done—we call them now "report cards" in some of the managed care entities—and we believe that that kind of information will help patients be able to make good decisions about which physicians and which facilities to use.

We are pleased to see that we are just beginning to have, unfortunately, the technology that allows us to accumulate that information, but in the next few years, it will become ever increasingly available and, more importantly, it will be valid and useful information.

Senator DEWINE. Doctor, just as an example, how do I know if I go to a doctor whether that doctor was denied privileges at a hospital 3 years ago? How do I know that, unless I live in a small community where everybody knows everything? How do I know that?

Dr. DICKEY. Well, my suggestion would be that you ask.

Senator DEWINE. So that every time I go see a doctor, I should ask him or her that question?

Dr. DICKEY. You certainly could. I have had patients ask me, "Have you ever done this before and how many times, Doctor?" And I answer them. But the other thing you could do is if you say, "Gee, I would rather go to Saint Thomas to have this done," and the doctor says, "I do not practice at Saint Thomas. Let's go to Saint Mary's." You might want to ask why, or "Did you ever practice at Saint Thomas?"

The other thing you can do is call the hospital in question and ask if the physician has ever been on that staff and how and why he or she lost privileges.

Mr. SCULLY. Senator, may I?

Ms. WITTKIN. Senator——

Senator DEWINE. Five minutes goes very quickly, Mr. Scully, but go ahead.

Mr. SCULLY. I would just express the frustration that for the last 15 years that I have been watching hearings on malpractice reform, they always turn into a debate over the quality of physicians and hospitals. I think that in any community in the country, physicians and hospitals are generally pretty highly regarded. There are bad hospitals, and there are bad physicians.

Senator DEWINE. Mr. Scully, excuse me. I do not think I was inferring anything. I was just asking a question.

Mr. SCULLY. I know; I was not saying that, Senator. I am sorry.

Senator DEWINE. I was asking a question. We are not debating that today, I do not think. I just want an answer to my question, if I could.

Mr. SCULLY. Well, I am saying that there is lots of outcomes data available on hospitals—I am not as familiar with the doctors, but there is quite a bit available on hospitals. There are definitely bad hospitals and bad doctors. But I think in most communities if you picked out what I see as the issue, and if you took the managing partners at Saiontz and Kirk, who advertise on the basketball games for malpractice, "If you have a phone, you have a lawyer,"

versus the head of any hospital or physician in the country, and put them at a table in front of your constituents, it would be a pretty clear choice, and that is what people are irritated about. They think the trial lawyers are out of control.

Senator DEWINE. Let me ask a general question if I could to all three of the witnesses. One of the arguments for retaining the current State system, which is basically a 50-State system, is that the current system serves as some form of a deterrent, that it does in fact alter behavior or alter results. I wonder if, very briefly, each one of you could address that argument. Is that a valid argument or not?

Ms. Wittkin, you were trying to say something a moment ago, and I did not mean to cut you off.

Ms. WITTKIN. I just wanted to respond to what Dr. Dickey said about disciplinary actions taken against doctors by hospitals being in the public domain, or denial of privileges. None of that is in the public domain. There is absolutely no way in the world that you will find out. You can call any hospital you wish, and there is no hospital that will ever tell you about if a doctor was denied privileges, why a doctor was denied privileges, or whether or not that doctor has been disciplined by the facility.

The State of Massachusetts is the only State right now that we know of that is even attempting to open up, through the board of registration and medicine, some of that information to the public.

But recently, there has actually been a study done that looks at the deterrent effect of medical malpractice cases, and if I may, Dr. Troy Brennan, who is one of the authors of the Harvard medical practice study, talked recently about an empirical analysis that was done on a hospital level which found that as liability claims increased per 1,000 discharges, the risk of negligent injury to patients in those facilities decreased. To quote Dr. Brennan, he said that "this is the first statistically significant evidence that there is a deterrent effect associated with malpractice litigation. It suggests that tort litigation, with all of its warts, nonetheless accomplishes the task for which it was primarily intended, that is, the prevention of medical injury."

Senator DEWINE. Mr. Scully.

Mr. SCULLY. Well, Senator, I would argue that essentially, for all intents and purposes, our hospitals are obviously insured, so that in an individual case, generally will pay for my insurance. If it is a third party issue, the costs get passed along to the insurer, and they get passed along to the consumer. I think that when you really look at an individual deterrent case on hospitals, is there a deterrent—absolutely. It is embarrassing to have a situation like the Tampa case. It is terrible for the community, it is terrible for the hospital and for the doctor.

As far as the level of the award, generally, that is put back in the malpractice insurance, and that is passed along as a cost to the system. So that on an individual case award, I would guess that if you went out and asked someone who ran 100 hospitals in our chain, or even one hospital administrator, are they really aware of what the final award is 2 or 3 years later, generally, they are not. They are very, very conscious of malpractice, and they are very

concerned about it, but it is a socialized cost that all of us are paying.

Senator DEWINE. So your answer is no, then.

Mr. SCULLY. I think we are highly sensitive.

Senator DEWINE. The question is whether the current law as it exists is a deterrent as opposed to if you impose caps—because that is really one of the main questions, I think, that the committee has to look at.

Mr. SCULLY. I would say that in the studies that I have looked at—and they are not very comprehensive—that in the 22 States that have significant caps, I think there is no evidence that there is any difference in the behavior in malpractice.

Senator DEWINE. Dr. Dickey.

Dr. DICKEY. I think I agree with Mr. Scully. I do not believe that the States with caps versus the States without show any difference. Certainly, I think the threat of a liability suit acts as somewhat of a deterrent to anybody acting casually or negligently. That works both ways. Certainly, it acts as a deterrent; on the other hand, it does not guarantee perfection. We have States both with and without caps, and errors still occur. So I think the real question is how do we make this system work best for those it was intended to make whole, and that is the injured patients. Evidence in the States that have caps suggests that in terms of that part of liability, the States with caps perhaps work better.

Senator DEWINE. Thank you. My time is up.

Thank you, Madam Chairman.

The CHAIRMAN. Senator Simon.

Senator SIMON. Thank you very much.

Ms. Wittkin, what happened to the physician who abused you? Was he or she disciplined?

Ms. WITTKIN. Thank you for asking that question. Actually, no, neither of the doctors was disciplined. I reported the doctors to the appropriate State medical boards, to the department of health in the State of California. I also—because in California, you can—went down to the courthouse and looked up the malpractice cases against each of the doctors, and they were numerous, and one involved a patient death, both before my malpractice and after my malpractice.

I got back a letter saying that there was not enough evidence to proceed in the case, and the doctors continued practicing.

Medical malpractice cases do not result in loss of license; they never do. It really has to do more with how doctors feel they are seen, or just the anxiety attached to being sued. It has no reflection on their ability to earn income, their ability to continue working, their ability to be licensed, their ability to have hospital privileges, because some of the higher malpracticing doctors in the country actually bring in extraordinary business to hospitals, so there is a disincentive to discipline those physicians.

Senator SIMON. Did you have a feeling that the disciplinary boards looked into this carefully?

Ms. WITTKIN. Oh, not at all. The way the physician discipline boards in this country are set up, they are underfunded, they are understaffed, and they are controlled by those who are being policed; in essence, it is the fox guarding the chicken coop. As a re-

sult, most malpractice cases are extraordinarily difficult and time-consuming to investigate. The States, for political reasons and otherwise, do not spend the time that they need to investigate these cases and to talk to the victims and to go ahead and bring some sort of disciplinary action against the doctors. And each State is different, so that what may be considered dangerous in one State is not considered dangerous in another State.

Senator SIMON. Thank you.

Dr. Dickey, you made a very interesting statement that in California, after the cap was applied, the number of suits increased. Why do you think the number of suits increased?

Dr. DICKEY. I think the number of suits actually has increased across the country. I think the indication is not that California is different than the others, but rather that having a case does not limit access of an individual who has been harmed from seeking redress in the courts. And the second part of that is that in the cases of severe injury, there are still multimillion-dollar awards in California.

Senator SIMON. You mentioned in your testimony that defensive medicine has decreased 30 percent in California. Defensive medicine sounds like a terrible thing, except that if I am the patient, I want defensive medicine. If the doctor believes there is one chance out of ten that the reason for my being in there is that I might have Lyme Disease, I want that physician to practice defensive medicine.

If you are a patient—and this is unfair because of your knowledge of the field of medicine—but don't you think you want a physician who is going to check out every reasonable kind of thing that could be going wrong?

Dr. DICKEY. I want my doctor to do reasonable kinds of things, but let me tell you about an example of defensive medicine in my practice in the last month.

I am a family physician who does obstetrics. In my hospital, the standard of care is we do not deliver breaches vaginally because of the potential for increased damage to the infant. One day while I was on call, and I and several others happened to be in the hospital for another meeting, a patient came through the emergency room. She had gotten all of her care from a lay midwife who had been laboring her that morning at home. It turned out she had a breach baby, and by the time the ambulance brought her—by the way, without the midwife—to the hospital, the breach, the baby's bottom, was visible and in fact protruding slightly from the vagina.

One of my obstetrical colleagues was there, and because they set the standard of care for we family physicians who do obstetrics, I thought perhaps he would try a vaginal delivery; this was really far-advanced. And instead, we proceeded immediately, urgently, to a Caesarean section on the patient. And the discussion with this doctor was absolutely, 100 percent defensive medicine. We did not know the patient, and we did not know her history. And because there is a slightly increased risk to the baby of a breach delivery, in spite of the imminent delivery, we did a Caesarean delivery. We did it because the potential cost of a lawsuit to that doctor, myself, and the hospital simply did not make it reasonable in his mind to do a vaginal delivery.

Now, that is not a blood test, and that is not a chest x-ray. That is a major operation with the risk of anesthesia, the risk of infection after surgery, and a scarred uterus that may impact her future deliveries. That is serious defensive medicine. It cost more, it hurt more, and it was not necessarily the best thing to do except that it protected us from the possibility of a lawsuit.

Senator SIMON. But in general, if you go into—that is an unusual situation, and I realize we are all——

Dr. DICKEY. I do not think so, Senator. We do lots of excess things. The worst cost is the cost of it in terms of just the tests and what it does to the cost of this terribly expensive health care system we have. The other costs can be pain and suffering, but the unmeasurable cost is also what it does to the doctor and patient.

I have been practicing for 15 years, and I have seen the relationship between the patient and myself in that exam room change as the threat of each person coming in, subjecting me to a lawsuit—about which there may not be any cause at all, or at least any basis when we get to court—changes how I interact with patients, and I think the patients are the losers.

Senator SIMON. I thank all three of you.

Thank you, Madam Chairman.

The CHAIRMAN. Senator Abraham.

Senator ABRAHAM. Thank you.

Ms. Wittkin, I was listening to your testimony about the failure—as you perceive it—or inability to find out information about the physicians who were involved in your case as well as the extent to which they had been subject to previous malpractice. Were there a number of previous malpractice claims brought against them?

Ms. WITTKIN. Yes, there were.

Senator ABRAHAM. What ran through my mind was that it would seem the current tort system for malpractice was not very effective in deterring these physicians. From what I gathered in the other parts of your testimony, that seems to be the case. You referred to the fact that the problem primarily is that of people who are repeatedly committing egregious—I think was the word you used—malpractice.

Is that, in your judgment and based on your analysis, the principal problem, that there is no policing?

Ms. WITTKIN. You are dealing with an isolated incident. The doctors that I am referring to are not necessarily the rule. They may be more the exception. But you are going to have, like in any profession, those doctors who continually malpractice who are not as good as other professionals are, just as you would have in law or in anything else. And whether or not it is a deterrent on a case-by-case, individual, doctor-by-doctor basis is something that I cannot assess based on looking at those two particular doctors.

Senator ABRAHAM. In your testimony, though, as you were describing your own situation, you then more generally said that the problem is focused on a group of physicians who repeatedly commit egregious malpractice. And I am trying to strike the right balance. Obviously, we are not going to totally do away with the civil justice system. What we are talking about in the legislation are some reforms that would—well, you know the legislation.

Ms. WITTKIN. Right, but I think that it extends beyond just looking at malpractice as an entity unto itself. You get the information from a malpractice suit, and all of that information under the law now goes to every State medical board, and every State medical board is supposed to investigate each of those malpractice case payouts and all the claims that come through. But do they? No. Do they act on them? No.

Senator ABRAHAM. I appreciate the point——

Ms. WITTKIN. So it does not work as well as a deterrent as it could possibly; however, it certainly does have a deterrent effect.

Senator ABRAHAM. I guess I am just trying to weigh in my mind, based on your testimony and your expertise with patients' rights, the extent to which the problem that we confront and are trying to address is going to be more effectively addressed by increased policing and licensing provisions versus maintaining what seems to me to be a tort system that is not doing the job every effectively, if your testimony is accurate as to the nature of the problem.

Ms. WITTKIN. I am not suggesting that we maintain the tort system as it is. As a matter of fact, we have recommendations in our testimony that talk about some of the things that we would like to see changed, because clearly there are not enough victims of medical malpractice being adequately compensated. There is absolutely no question about that.

However, one thing really has nothing to do with the other. We are not talking about maintaining the system for the system's sake. What we are talking about is medical malpractice prevention. Both have to be done.

With every tort reform that has happened—and we look at it State by State—there has always been a promise of stronger discipline, more money for State medical boards, better oversight, better policing. None of that ever happens.

So what we are saying is that we are continually putting the cart before the horse. We are taking away victims' rights with the promise of putting in place systems that will protect people—but in fact we do not do that.

Senator ABRAHAM. I understand. OK. I am just trying to in my own mind sort out what the proper solutions are, at least for that part. There are two reasons to have a civil justice system. One is deterrence, the other is to compensate people who are injured. And we will obviously maintain the system for the second purpose. However, with respect to the first purpose, my understanding of your testimony was that the current system has not succeeded because the problem tends to be in the discipline side rather than in the remedy side.

I want to ask Dr. Dickey and Mr. Scully to comment—one of the issues raised here was the notion of putting caps, not just on punitive damages, but also on some form of either total damages, or I guess pain and suffering, really, is the area that is not capped under the proposal.

I am not necessarily comfortable with that as an across-the-board approach. I am wondering what your thought would be about linking some form of cap to the early offer provisions of the legislation, that is, that there might be caps applied in the context of trying to bring about some sort of early settlement of cases where the neg-

ligence is acknowledged and where we would presumably both bring about early resolution and at the same time, for victims, as Ms. Wittkin indicated, who should be able to receive their awards early, they would get them under that kind of an approach.

What would your thoughts be to applying it in that context?

Dr. DICKEY. Well, Senator, one of our concerns is the length of time it takes for patients who have been damaged to get their awards, so we are very interested in looking at the early settlement clause. Now, whether tying caps just to that or tying a differential of caps to that versus other, I think what we would probably suggest is that we would want to look at that very carefully and the specific wording or even, like some others, see a State or two try it and see what impact it has. Sometimes, we have solutions that sound good on paper, but when tried in reality have unintended consequences.

I think the important thing about the caps in terms of noneconomic damages, Senator, is that we have had that experiment going on in California for over a decade, and for a period of time in some other 19 States, and it has worked; it has helped to improve the system so that it works better to compensate those who have been injured.

Senator ABRAHAM. Mr. Scully.

Mr. SCULLY. We would agree. We would obviously be wiling to—our position is we would like a $250,000 cap, but we would obviously be willing to look at any reasonable facsimile that patches pieces of the bill together.

It is not just California, by the way. It is California, Colorado, Kansas and Utah. All have $250,000 caps, and there are seven other States that have even tighter total caps. And our view is we have not seen any evidence—certainly, no difference in any malpractice outcomes—and we have seen absolutely no evidence, except for happier trial lawyers, in any of those States outside of that that there is a difference.

So that after 20 years of debate, our view is that the burden of proof is to show why States like California, Kansas, Utah and Colorado do not have better economic systems for all patients, have just as good outcomes with malpractice, and do not save the whole system an awful lot of economic damage.

Senator ABRAHAM. Thank you very much.

The CHAIRMAN. Senator Gorton.

Senator GORTON. Ms. Wittkin, one of the elements of the bill before us today that I do not believe your written testimony covers is the portion of it which is called "Biomaterials Access Assurance Act." The story that Senator Lieberman told was that a manufacturer with $600,000 worth of sales of Teflon has had to spend $8 million a year for 6 years in defending medical malpractice cases for devices that use some portion of that Teflon—all successfully—and made the business decision, why should they sell Teflon for this device any longer.

The response to that on the part of Senator Lieberman is to exempt the supplier from liability unless the materials do not meet contractual specifications or unless the manufacturer is also the manufacturer of the device.

Is that in your view a reasonable response to this fairly narrow area? Should the manufacturer of that raw material be subjected to the medical malpractice lawsuit under cases like that?

Ms. WITTKIN. Senator, unfortunately, that goes beyond my area of expertise, and it really deals with the product liability end of it, and I just do not feel comfortable speaking to that.

Senator GORTON. That is fair enough. A second question for you. I represent the State of Washington, which is one of five States in which punitive damages are not available in civil actions at all; caps are just simply deemed to be inappropriate. Do you have any evidence to indicate that the practice of medicine is lower in those five States, or that victims of true malpractice are inadequately compensated in those States?

Ms. WITTKIN. Can you explain to me what you do not have in the State of Washington?

Senator GORTON. Punitive damages.

Ms. WITTKIN. You do not have punitive damages.

Senator GORTON. At all.

Ms. WITTKIN. Punitive damages do not apply in medical malpractice cases, Senator, so it would not be a way to gauge whether or not there is any effect.

Senator GORTON. So you do not object to a cap on punitive damages as a part of medical malpractice legislation?

Ms. WITTKIN. The punitive damage cases that I know about are cases that involve the sexual abuse of patients by physicians for the most part, and I think certainly in those cases, yes, we do want to send a loud, clear message to those individuals who are committing these heinous acts.

Senator GORTON. Then, I return to my question. Is there any indication that there is more sexual abuse by physicians of patients in the five States that do not have punitive damages?

Ms. WITTKIN. The sexual abuse of patients is really a criminal act, and it goes beyond the scope of medical malpractice, so it really does not tie in with—when we talk about medical malpractice and punitive awards in medical malpractice cases, the sexual abuse case is really outside of that.

Senator GORTON. Well, I guess I have to take it that, at least with respect to punitive damages, a cap on them or even their existence is not a central feature of your opposition to this bill.

Ms. WITTKIN. No, but what we do oppose is the idea that you are using a nonexistent award to fund a quality assurance program for States that is now going to be federally mandated, which will do absolutely nothing because there will be no money to run the program.

Senator GORTON. Thank you. Do not say "me"; that was not my idea.

Mr. Scully, on the other hand, I think that Ms. Wittkin has a valid criticism of the dispute resolution provisions of this bill, and I wonder if you consider it to be fair that we both create a mandated dispute resolution procedure in every State and then say that a patient's refusal to accept the results of that system creates a burden of proof in court beyond the reasonable doubt, a criminal burden of proof, which seems to me for all practical purposes to say

that no one under any circumstances is going to dare bring a malpractice case.

Doesn't that go further than you advocate?

Mr. SCULLY. Well, I always try to agree with you and Senator Kassebaum; that is not possible here, I guess. Our view, HCLA's view, is that we do not support mandatory alternative dispute resolution, although we are certainly willing to see it in the bill, and we support the bill as a whole.

Our view has been to leave that option to the States. I believe that that was also the view of the Bush plan I alluded to earlier, which was to leave the option to the States, although encourage it fairly strongly, through a number of different mechanisms.

Senator GORTON. I am relieved to hear that, Mr. Scully.

Dr. Dickey.

Dr. DICKEY. Actually, we too have some problems with the alternative dispute. In fact, in places where ADR has been used—and the evidence is not there; in medicine, it has not been used very much—that using it may actually divert more cases to the courtroom rather than speed the system. So we do have some concerns with it, and as I suggested to Senator Abraham, if you want to do it, it may well be that we should at the very most look at it in a State or two and see if it has the impact we wish rather than an unintended consequence.

Senator GORTON. Thank you.

Thank you, Madam Chairman.

The CHAIRMAN. Thank you.

Senator Wellstone.

Senator WELLSTONE. Thank you, Madam Chair.

I apologize to the panelists because I have been in and out, but I sprinted back here to make sure I would at least have the chance to ask a few questions.

Madam Chair and distinguished panelists, I am not a lawyer—I was a college teacher—and that is not, by the way, a subtle putdown of lawyers; I do not have my "I am not a lawyer" button on today, or anything like that. It has to do with a whole different set of issues that I want to raise.

It seems to me that the basic focus of all this, or of any kind of reform legislation, would be to determine two things. First, as we look at a bill that purports to be a reform bill, is it going to deter malpractice from happening; is it going to deter what clearly is sometimes gross negligence; will it do that? And then the second criterion is to make sure there is fair compensation for consumers when that does happen. Those are my criteria, and I must say I do not think S. 454 meets that.

So if those are my criteria, I guess the first question I have for you is why not more of a focus on preventing the malpractice in the first place. I know that Senator Kennedy raised that question before, and I would say to you, Dr. Dickey, that last year, you all were strongly supportive of the Patient Protection Act. This year we have reconfigured it and I think we have made it a much better piece of legislation—legislation that really does deal with developing quality standards and risk management procedures and practice guidelines for health plans to provide some protection for consumers. Why not more of a focus on that?

Dr. DICKEY. Senator, if I may, we would be delighted to see those kinds of things. I think you are absolutely right. We need to look at this from the issue of does it deter, and second, does it better serve society and the consumer who has been injured.

I think we have heard a fair amount of testimony that while the liability threat probably does deter some, it certainly raises the level of consciousness, but even in a system of unlimited recompense, it cannot prevent all human error. I do not think the proposed bill either improves or makes worse the deterrence mechanism.

We would love to work with you and the others on moving forward patient protection things that would improve deterrence. But what we have before us is S. 454, and it does give us an opportunity to improve the second goal, which is it is supposed to both help pay that individual, help make whole the individual who has been damaged, and it should serve society well.

Today's litigation neither effectively deters, nor does the second half. S. 454 would move us in the direction of making patients whole. It would be quicker, it would make sure that more of the dollars go into the injured patient's pocket than into the system, if you will, and it would quit making it a lottery.

One of the concerns today is that many who have had negligence or bad outcomes do not get into the system because, frankly, the award will not be big enough to attract a contingent fee, so they are not helped. Many who get into the system lose most of the payment into the system rather than into their pockets, and it is a terribly drawn out and difficult system to navigate.

So we think S. 454 is a step forward on the second half of what you want a liability bill to do.

Senator WELLSTONE. I am just going to rephrase my question and then let each of you respond, and then I will conclude, because I know we are running out of time.

Again, I would say to you, Dr. Dickey, the AMA has been supportive, and now we are really focusing on the Health Care Quality and Fairness Act—that is what we are calling it—and I appreciate that. I think there has to be some basic due process, some basic protections and basic access to information, and a real focus on the quality of these plans to deter malpractice in the first place.

But my concern is that I see the wrong incentives in the approach that S. 454 takes. That is to say, this one-way preemption of States when States want to have fairly rigorous consumer protection standards in terms of the compensation caps they have, but then no basic standards set if States do not want to have any kind of strong consumer protection. This seems to me to be inconsistent, and I do not see how these compensation caps act as a deterrent. I also want to go back to the second point—it seems to me that S. 454 works against the other, what I think should be the basic goal of any reform legislation, which is to make sure consumers get fair compensation. That is my concern. So that on both counts, I do not see that S. 454 meets the goals of reform, and that is what I would like the other two to respond to. That is my criterion, and I do not think this legislation meets it at all. Tell me why I am wrong about that, or if you think I am right, that would be appreciated—tell me why I am right.

Mr. SCULLY. Just briefly, I do not think that we believe anybody wants to limit reasonable compensation to patients. What we believe is that the litigation system is out of control. It is structurally out of control. A hospital or a rural health clinic that has marginal involvement in a malpractice suit, if the physician dies or becomes bankrupt or something, joint and several liability, for instance, and no caps, you can go after that clinic, and if it has one percent liability, get an enormous award from it.

Senator WELLSTONE. If I could interrupt you, I understand that problem, but then the question becomes who should make up the compensation to ensure that the consumer is protected.

Mr. SCULLY. Well, I guess our view is, if you look at the evidence State by State, even those States that have really tough caps—and the toughest two in the country are Louisiana and New Mexico; and I would bet if you asked Senator Bingaman and Senator Breaux, and I deal with both of them a fair amount, I have never heard either of them say that there is a rash of consumer complaints—and those are the two toughest States in the country—and outrageous complaints of consumer abuses in those States by hospitals or doctors. So I guess our view is that we definitely want to get down to defending consumers; we definitely want to make sure that consumers who have had outrageous malpractice problems are compensated fairly.

The question is where do you find the fair balance between rational compensation of patients and rationally running a completely screwed up litigation system.

Senator WELLSTONE. I understand that point, and it is well-said. Ms. Wittkin.

Ms. WITTKIN. Senator, the concern that I have about the compensation aspect of this legislation is that with the alternative dispute resolution mechanism, you are guaranteeing and assuring that there will not be cases brought to court.

Senator WELLSTONE. Because of the standard?

Ms. WITTKIN. Because of the standard of proof, coupled with the fact that you have to prove gross negligence or intentional cause for harm. So you are meeting a standard that there is not a lawyer I know who would walk into court and try to meet in a malpractice case, particularly when you talk about malpractice, you are very often talking about fraud, coverup, destruction of evidence. Those are the kinds of things that go hand-in-hand with medical malpractice cases, so they are difficult enough to prove as it is. Putting that burden of proof on top of it is going to make it possible.

So that what will happen is that everybody is going to be railroaded into ADR, and what they are doing in essence is—who is paying the lawyer fee? How much is a lawyer going to be compensated to deal with that victim? Who is doing discovery to find out what the true extent of that person's damages will be? And they are making you an offer you cannot refuse, because if you do not accept the offer of ADR—and let us say you are not someone who is very sophisticated and able to deal with all of the medical issues and economic loss issues—what lawyer is not going to accept something in that system, rather than try to bring that case into the court system? So I think you are going to end up with system-

atic undercompensation of victims by literally pushing them against the wall and giving them absolutely no alternative.

Senator WELLSTONE. Thank you, and I would like to thank each of you for your thoughtful responses. Again, we are constrained by the time limit, and I am sure it is frustrating to you, and it is frustrating to all of us in terms of follow-up. But I very much appreciate your responses. I am looking for the balance, and I am just trying to figure out how you prevent malpractice from happening in the first place and how you then make sure there is fair compensation. That is where I want us to get to, and I do not think we are there.

Dr. DICKEY. If I could, Madam Chairman.

The CHAIRMAN. Dr. Dickey.

Dr. DICKEY. For just a second, Senator Wellstone, it is very important that we not confuse fair, adequate compensation for paying the health care costs, replacing the economic losses that a patient has, for making whole economically the economic impact of the injury. We are talking only about the need for a cap on the noneconomic damages——

Senator WELLSTONE. I understand.

Dr. Dickey [continuing]. The pain and suffering, those things that are somewhat more intangible and difficult to put a price tag on. But there is no limit on the ability to recompense a patient for demonstrable losses.

Senator WELLSTONE. I understand, and we could have quite a discussion on that point, and I understand what you are saying.

Mr. SCULLY. I would just like to thank the committee, Senator, for taking the time to do this this morning.

Senator WELLSTONE. Madam Chair, I am not talking; I want you to know that now. I am not going over my limit.

The CHAIRMAN. I know.

Mr. SCULLY. We appreciate very much your having this hearing this morning, and we hope the Senate has this level of detailed debate. We believe that if all the issues are debated in detail, it will come up with a much more sane, rational system than we have now. So thank you very much.

The CHAIRMAN. Senator DeWine, do you have another question?

Senator DEWINE. I do. Mr. Scully, I just cannot resist this, and I apologize to the chairman. But let me read a portion of your written testimony, and you covered it also in your oral testimony.

"S. 454 makes these reforms as a Federal floor and protects State law that goes beyond the Federal floor. There are many States that have been leading the way on tort reform, and they should be able to hold onto the gains they have made."

What is the logic behind that statement? I understand what you are trying to accomplish, but what is the logic behind saying we are now going to do something—which to my knowledge, we have never done in the history of this country before—which is to have it uniform, all 50 States moving into the civil area tort reform, or make it uniform throughout the country, except in those States that, if you will forgive me, from your point of view, do a better job and make it more restrictive—those, we are going to let do what they want to do. What is the logic behind that? It may be good policy, but I do not find it very logical.

Mr. SCULLY. Realistically, if we could find a reasonable policy, I would probably be for a standard, 50-State policy, but politically the fact is I do not think you could get what I would consider a reasonable policy nationwide, similar to California.

For instance, last year, I think Senator Kassebaum had the aviation liability bill, and just on that example, I think it left a number of States with different levels of aviation liability; the same thing with the civil justice reform bill a couple of years ago. Just as a rational political option, there are States that are going to have different levels that are politically acceptable, and I think that realistically, we do not think that it is likely to get a national standard that is going to be tight enough that it is going to live up to what I think you will find very happy consumers, very happy physicians, and very happy hospitals in California. I do not think they are going to be very happy if they are forced to drop to a lower standard.

Senator DEWINE. Thank you.

The CHAIRMAN. Senator Kennedy.

Senator KENNEDY. Thank you, and I thank you, Madam Chairman.

I find it fascinating that at a time when the common wisdom is that Washington does not always know best, that we do not want strong Federal regulations, we do not want Federal interference in State regulations, and what we want to do is rely on the market to try to enforce safety. That way, we do not have Federal and State regulations. This whole proposal, I believe in a very significant and dramatic way, will dampen the legitimate interests and rights of our fellow consumers for so many of the excellent reasons that have been outlined here.

We hear that the current system has its problems. We did not talk very much about the problems that exist with insurance companies, which are making extraordinary profits. We've heard criticism of trial lawyers, and maybe some of them deserve it, but we have not talked about the billions of dollars in insurance profiteering and the explosion of profits that has gone on there. And we spent very little time talking about the hundreds of thousands of people who are victims of malpractice and never get any kind of compensation, as tragic as it is.

And nonetheless we are being asked now to preempt State laws by many of those who were so wary about doing that even less than a year ago, or at least preempting them if they have some particular advantage to consumers.

Today we did not get into the issue of punitive damages very much, in terms of who is going to be the most adversely impacted. Ms. Wittkin gave a brief response—it is going to be women in our society. We did not talk about how a cap is going to damage women in our society and how they are going to be disadvantaged. We did not get into that at all except for a brief comment by Ms. Wittkin.

And we spent very little time in this hearing talking about the recommendations that Ms. Wittkin has proposed. Her testimony includes a whole series of recommendations in terms of how this will impact consumers, the members of our families, our fellow Americans—and the issue of children. Children have not been talked about much here. We talked about efficiency and damage caps,

changes in burden of proof. But we are talking about terminally ill children.

I note that Ms. Wittkin's recommendations even talk about a cap on defense attorneys' fees. So she is even-handed in her very thoughtful commentary, and I just want to thank Ms. Wittkin for these recommendations. This is enormously important.

As I mentioned at the outset of the hearing, it is extraordinary to me that one of the first things we are doing here is preempting the States. This is entirely different from product liability, where you have matters going from State to State. You would think that people in their local communities would be able to make this judgment; you would think States ought to be able to do it.

But right out of the chute, we are not dealing with health care in this committee; we are talking about diminishing and denying the interests and protections of consumers. And I hope there will be a full opportunity for debate on these issues, which are enormously important in terms of the legitimate interests and rights of our fellow citizens. There are quality issues that relate to our efforts at preventing the indignities and injustices of malpractice, and I wish we could be giving equal attention to all of them.

I want to thank all of our witnesses. Could I just ask Ms. Wittkin, were caps in effect in California that applied to your case?

Ms. WITTKIN. Yes. About 6 months before my case went to trial, the decision was upheld in the State of California, so the cap applied in my case.

Senator KENNEDY. So that is certainly one of the consequences. We are talking about what happens in the current system versus a changed system. What we do know is that in a State which passed damage caps, you were disadvantaged in terms of your own circumstances. We thank you very much.

The CHAIRMAN. And I certainly agree with you, Senator Kennedy. This is a very important subject. I would just point out that under California law, there is a cap of $250,000 on noneconomic economic damages; is that not correct, Ms. Wittkin?

Ms. WITTKIN. That is correct.

The CHAIRMAN. And so the cap that covered Ms. Wittkin is not in this bill, even though there has been a lot of talk about it; and actually, the cap that we have on punitive damages, if I heard the testimony and comments correctly from everyone, would not really make much difference, that it is the noneconomic damages that really do matter. So I think, even though we did not touch on it to any great extent, at least that is what I heard.

But I share with you that this is a very important subject, and we have heard some very important testimony today, and it is testimony that we will all take into consideration as we work on this legislation. So I thank you very much. It has been a pleasure to have all of you here.

Senator KENNEDY. Thank you, Madam Chairman.

[Additional statements and material submitted for the record follow:]

PREPARED STATEMENT OF THE AMERICAN BAR ASSOCIATION

Madam Chairwoman and members of the committee: I appreciate the opportunity to present the views of the American Bar Association on S. 454 and on medical professional liability in the context of proposals to increase access to health care. I am

Philip H. Corboy, Chair of the ABA's Special Committee on Medical Professional Liability.

Since 1972, the ABA has been on record in support of legislation that would provide for every American to have access to quality health care regardless of a person's income. In February 1992, and again in February 1994, the ABA's House of Delegates reaffirmed its support of legislation calling for universal coverage for all through a common public or public/ private mechanism through which all contribute.

The American Bar Association is concerned about the ability of Americans, including its own members, to obtain affordable health insurance. Health care at a reasonable cost has been an American expectation, and a concept the American Bar Association supports. Likewise, access to the American legal system has been a fundamental right tracing back to the origins of this country.

The ABA understands the concerns being expressed about the issue of medical professional liability and is deeply committed to having a legal system in America that is effective and just, one that protects the rights of plaintiffs and defendants. Two ABA entities worked toward this end by developing recommendations for the ABA's House of Delegates. They are the Special Committee on Medical Professional Liability and the Action Commission to Improve the Tort Liability System.

The ABA Special Committee on Medical Professional Liability was composed of a balanced group of plaintiffs' lawyers, defense lawyers and representatives of academia, and the judiciary. The Committee was chaired by ABA Past-President Talbot S. D'Alemberte, then Dean of the Florida State University College of Law. The Committee was charged with studying legislative initiatives in the medical malpractice area and developing ABA policy proposals for the Association's policymakers to consider. In February 1986, the ABA House of Delegates adopted a resolution upon recommendation of the Committee. (A copy of that resolution is appended to this statement as Appendix A.) The Committee was then disbanded. However, it was reactivated in August 1991.

Near the end of 1985 the ABA, through its President, appointed an Action Commission to Improve the Tort Liability System. The 14-member Commission was asked to develop specific proposals to improve the tort liability system. The members of the Commission were federal trial and appellate court judges; a State Supreme Court Justice; corporate counsel, including those with insurance experience; consumer and civil rights advocates; academicians; and practicing plaintiffs' and defense lawyers.

In February 1987, the ABA House of Delegates considered the Commissions recommendations and adopted the resolution appended to this statement as Appendix B. The ABA takes the position that these proposals to improve the tort system can and should be implemented by the courts and legislatures at the state, and not the federal level. The tort system has shown considerable resilience in the face of dramatic social and economic developments. State courts and legislatures are constantly working to improve the tort laws and should be permitted to continue to do so. Thus, federal intrusion into the field, with some discrete exceptions, is inappropriate.

The ABA believes that federal pre-emption of the state medical professional liability laws would constitute an unwise and unnecessary intrusion of major proportions on the longstanding authority of the states to promulgate tort law. Such pre-emption would cause the whole body of state tort law to become unsettled and create new complexities for the federal system. Unequal results would occur when medical professional liability litigation is combined with other fields of law with differing rules of law. An example of this would be a situation where a medical malpractice claim is joined with an automobile liability claim. If state tort laws differ from the federal law in areas such as caps on damages, the collateral source rule or joint and several liability, conflicts and uncertainty would likely result; and one defendant in an action could well be treated entirely differently than another. Having one set of rules to try medical professional liability cases and another set of rules to try other tort cases is not consistent with the sound and equitable administration of justice.

Our ABA policies reflect the ABA's recognition that the issue of medical professional liability is of vital importance not only to the legal profession but to the medical profession, the insurance industry and, most of all, to the public.

The public has the most at stake in this issue. When a person suffers injury as a result of negligence by a provider of health care services, he or she must have the right to seek recovery for the full measure of those damages. We believe that right is severely threatened by those who call for major changes in this country's tort law system, and particularly by those who propose that limits be placed on the amount of damages persons may seek in compensation for their injuries caused by the negligence, or carelessness of health care providers.

We are especially concerned with proposals to alter the system of medical malpractice to carve out exceptions in the tort law system for one group of potential defendants—in this case, the medical profession. It is the ABA's belief that the rights of injured persons to recover fully from injuries caused by the wrongful acts of others must be protected. We are concerned that those who seek major changes in the way the tort law system deals with cases of medical malpractice are willing to trade away the rights of all individuals in the hope of easing a perceived burden on some or reducing the overall costs of health care. Since medical malpractice insurance costs make up only a small fraction of the dollars spent on health care in the United States, the changes in the tort laws would have no real impact on costs of health care.

In addressing access to health care proposals that contain provisions on medical professional liability, three questions need to be asked. First, what is the cost savings that can be achieved? Second, have such provisions, when enacted, lowered health care costs in states which have adopted their essential elements? Third, what are the consequences to the traditional American legal system and to the rights of the injured persons? In other words, does a cost shifting from the medical professional who caused the injuries to the person who was injured or to a governmental agency achieve anything more than an illusory savings?

WHAT IS THE COST OF THE MEDICAL LEGAL SYSTEM?

The American Bar Association does not purport to possess the expertise to analyze all of the reasons for escalating medical costs. We do, however, have the ability to analyze the interrelationship of the legal system and those costs. Moreover, we are able to determine the consequences of proposed legislation upon the American legal system and those seeking compensation for injuries.

The major components that have been cited as contributing to the rising cost of that care are:

- Reliance on modern, sophisticated and expensive treatment;
- Innovative treatment of illnesses, such as heart disease, AIDS and cancer;
- An aging population, which adds to Medicare and Medicaid expenditures;
- High administrative costs of the health care system; and
- The medical-legal system.

Studies concerning the medical-legal system show that its impact on the national expenditures is not only questionable but also insignificant. The Congressional Budget Office stated in 1992 that medical-legal costs, as measured by medical malpractice insurance premiums, account for 0.74 percent of the national health expenditures.[1] I understand that these insurance premiums account for a lower percentage of national health expenditures at this point in time. The other component of cost attributed to the legal system is that of so-called "defensive medicine." Varying figures for the cost of "defensive medicine" have been estimated. However, no one has reliably measured what, if anything, defensive medicine costs.

An October 1992 study of the Congressional Budget Office concluded that health care spending is propelled upward by high-cost technological and medical breakthroughs. The study finds that rising incomes, demographic changes, and medical malpractice costs do not appear to account for much of the increase in the nation's health care bill. The report states that malpractice insurance premiums account for less than one percent of the dollars spent annually on the nation's health care.

The report also concluded that "much of the care that is commonly dubbed 'defensive medicine' would probably still be provided for reasons other than concerns about medical malpractice. Physicians have always sought to provide patients with the best possible medical care at the lowest risks and would continue to do so even without the threat of lawsuits. Because much of this 'defensive care' helps to reduce the uncertainty of medical diagnosis, it seems unlikely that physicians would change their practice patterns dramatically in response to malpractice reform."[2]

To address the subject of "defensive medicine," there must be agreement upon the meaning of the phrase. However, there is no agreement upon the definition.[3] That

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[1] Testimony, Robert D. Reischauer, Director, Congressional Budget Office, Statement before the Committee on Ways and Means, U.S. House of Representatives, March 4, 1992.

[2] Congressional Budget Office, Economic Implications of Rising Health Care Costs (October 1992) page 27.

[3] The American Medical Association has estimated the cost of defensive medicine based upon a survey of physicians who were asked, for example, whether they ordered more tests because of the perceived risk of a medical malpractice claim. The AMA, moreover, recognized other reasons contributed to an affirmative response, stating, "like other defensive measures, all defensive medicine cannot be characterized necessarily as overuse but can reflect necessary improvements in patient care". Statement on behalf of the American Medical Association to the Senate

uncertainty has resulted in the inability to statistically measure the cost.[4] In some published studies, "defensive medicine" has included erroneously the cost of the consequence of physicians' financial incentive to direct patients for tests and examinations in facilities in which physicians have a proprietary interest.[5] Some have considered the cost of new technology and advancements in medical knowledge, care and treatment. In that regard, patients expect the use of very modern, sophisticated and expensive technology to refine diagnosis and eliminate uncertainties.

Therefore, to examine the impact of the medical-legal system, the necessary inquiry is to what extent physicians direct medical expenses that are unwarranted for the treatment or diagnosis of patients, and are not motivated by personal financial interests. In other words, an expense is only attributable to the medical-legal system when the sole reason for that expense is concern by the physician about a medical malpractice claim. There has been no study to specifically measure that cost, and there appears to be no basis for assuming that competent and reputable physicians impose such expenses upon their patients without a justifiable medical reason.

To the extent that physicians' concern about liability results in more conscientious medical care, then "defensive medicine" is certainly desirable.[6] When the fear of tort liability deters medical injuries, then health care costs are lowered by avoiding the costs associated with medical injury.[7] Thus, if liability concerns are a deterrent, provisions that relieve physicians of concern regarding negligent practices can actually result in an increase of health care costs.

The Office of Technology Assessment recently released a report that attempted to determine the cost of "defensive medicine". Under OTA's definition, a "medical practice is defensive even if it is done for other reasons (such as belief in a procedure's effectiveness, desire to reduce medical uncertainty, or financial incentives), provided that the primary motive is to avoid malpractice risk". The study found that "it is impossible to measure the overall level and national cost of defensive medicine". It found that "many physicians say they would order aggressive diagnostic procedures in cases where conservative management is considered medically acceptable by professional expert panels" and that "most physicians who practice in this manner would do so primarily because they believe such procedures are medically indicated,

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Finance Subcommittee on Medicare and Long Term Care Regarding Medical Liability Reform, October 16, 1991, page 4.

[4] The Physician Payment Review Commission (PPRC) has questioned such figures, noting that "Studies that use physicians' estimates of the amount of defensive medicine they practice are not sufficiently reliable to make quantitative estimates". *Physician Payment Review Commission 1991 Annual Report to Congress.*

ERR14[5] Mark N. Cooper, "Physician Self-Dealing for Diagnostic Tests in the 1980s: Defensive Medicine vs. Offensive Profits", Consumer Federation of America, October 3, 1991, reported that the rapid spread of physician ownership of diagnostic testing facilities is a much more likely cause of rising diagnostic costs than fear of malpractice liability.

A January 1991 study by the State of Florida's Health Care Cost Containment Board looked into physician ownership of health care facilities. It found that joint ventures among health care providers resulted in higher health care costs due primarily to the over-utilization of services.

A study of radiation centers in Florida found that doctor-owned centers appeared to result in a substantial increase in use and cost of the services. See Mitchell, Jean M.; Sunshine, Jonathan H.; "Consequences of Physicians' Ownership of Health Care Facilities—Joint Ventures in Radiation Therapy, The New England Journal of Medicine, Vol. 327, No. 21, Nov. 19, 1992, pages 1497–1501.

Another study examined workers' compensation claims in California and found that self-referral increases the cost of medical care covered by workers' compensation for physical therapy, psychiatric evaluation services and MRI scans. Swedlow, Alex; Johnson, Gregory; Smithline, Neil; and Milstein, Arnold, "Increased Costs and Rates of Use in the California Workers' Compensation System as a Result of Self-Referral by Physicians". The New England Journal of Medicine, Vol. 327, No. 21, Nov. 19, 1992, pages 1502–06.

[6] Patricia M. Danzon, "Liability for Medical Malpractice", Journal of Economic Perspectives, Vol. 5, No. 3, Summer 1991, pages 51–69. Ms. Danzon concludes that liability concerns have brought about some efficient changes in practice.

The Physicians Payment Review Commission Annual 1991 Report also discusses other possible causes of inefficient and inappropriate defensive medicine.

Physicians and hospitals often benefit financially by delivering more care.

Insurance does not deter physicians from ordering additional tests because insurance provides funding for that which a patient could not otherwise afford.

So-called defensive medicine practices often have become the standard of care adopted by the medical community, and reflect an advancement in technology or care.

[7] Testimony, Robert D. Reischauer, Director, Congressional Budget Office, Statement before the Committee on Ways and Means, U.S. House of Representatives, March 4, 1992, Appendix F, page 32.

not primarily because of concerns about liability". It found that "only a few clinical situations represent clear cases of wasteful or low benefit defensive medicine".[8]

HAVE TORT PROPOSALS, WHEN ENACTED, LOWERED OVERALL HEALTH CARE COSTS?

It is often asserted that caps on noneconomic damages and elimination of the collateral source rule result in lower health care costs for everyone. In general, these types of proposals have been enacted only within the last ten years. Insufficient time has elapsed, and insufficient data has been gathered to enable us to be certain of the impact on costs of these proposals. However, from our research and study it appears that these proposals have not had any measurable impact on overall health costs. In looking into the issue we found that personal health care spending per capita approximately doubled throughout the United States from 1982 to 1990 regardless of whether a state had enacted "tort reforms" and regardless of the type of "reforms" enacted. We developed a chart (attached as Appendix C) showing the percentage of increase from 1982 to 1990 in personal health care spending per capita by state. It is derived from a February 1992 report entitled "Health Care Spending—Nonpolicy Factors Account for Most State Differences," published by the General Accounting Office (GAO). The GAO report utilized 1982 data compiled by the Health Care Financing Administration (HCFA) and 1990 estimates from Lewin/ICF.

As the chart demonstrates, personal health care costs approximately doubled from 1982 to 1990 regardless of whether a state had enacted tort "reforms" and regardless of the type of "reforms" enacted.

For example, based on the figures utilized in the GAO report, the three states with percentage increases estimated to be slightly lower than average—Arkansas, Kentucky, and Mississippi—had no caps on damages in medical malpractice cases. Alabama, with a slightly higher than average estimated percentage increase, had a cap on damages. Massachusetts and California, the two states with the highest estimated personal health care costs per capita, had in place a cap on damages.

Our findings are consistent with other studies. For example, in March 1993, the Coalition for Consumer Rights published *False Claims: The Relationship Between Medical Malpractice "Reforms" and Health Care Costs*. This study found there to be "no indication that enacting major tort 'reforms' is positively correlated with lower health care costs." In fact, the study found that "states with the lowest per capita expenditures are more likely to have enacted fewer tort 'reforms' overall than the average."[9] Regarding caps on damages, the Coalition's study concluded as follows:

Since the medical establishment has made caps on damages its single highest priority, we would expect to see some correlation between states which have limits on recovery and inexpensive health care. However, only 30 percent of the ten states spending the least in health care have enacted limits on recovery of damages; 55 percent of the remaining 40 states have such a statute. A closer examination of the states ranked by spending shows that there is no correlation between the least expensive states and limits on damages.

Our findings are consistent with previous research we have conducted on the "health care savings" of caps. Indiana has one of the most restrictive caps laws in the nation, and yet a 1992 survey of hospital bed costs and delivery charges in comparable cities in Illinois and Indiana revealed that the small variance in fees could not be attributed to lower medical malpractice costs coming from caps on awards.

A 1992 study funded by the Texas Medical Association, the Texas Trial Lawyers Association and the Texas Hospital Association reported that its findings indicated that "changing the medical professional liability system will have minimal cost savings impact on the overall health care delivery system in Texas.[10]

The cost of medical malpractice insurance, for the most part, reflects the cost of the medical-legal system. In contrast to the increase in health care costs, medical malpractice costs have been relatively stable in recent years.[11] The number of medical malpractice claims peaked in 1985, and has continued to decline according to

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[8] U.S. Congress, Office of Technology Assessment, Defensive Medicine and Medical Malpractice (July 1994) pages 1–2.

[9] Andrea Dubin, *False Claims: The Relationship between Medical Malpractice "Reforms" and Health Care Costs*, prepared for the Coalition for Consumer Rights, March 1993, page 2.

[10] "Medical and Hospital Professional Liability," a report prepared for the Texas Health Policy Task Force by Tomm and Associates, July 1992.

[11] *1989 Profitability Study (By Line By State) 1990 Profitability Study (By Line By State), 1991, Profitability Study (By Line By State), 1992 Profitability Study, (By Line By State), National Association of Insurance Commissioners, 1990, 1991, 1992 and 1993.*

the most current figures we have found. From 1985 to 1990, the overall rate declined at an average annual rate of 8.9 per cent.[12]

A recent study by the Office of Technology Assessment found that "traditional tort reforms—particularly caps on damages and amendments to the 'collateral source' rule—reduce malpractice insurance premiums, but their effects on defensive medicine are largely unknown and are likely to be small. To the extent that these reforms do reduce defensive medicine, they do so without differentiating between defensive practices that are medically appropriate and those that are wasteful or very costly in relation to their benefits".[13]

WHAT ARE THE CONSEQUENCES TO THE PUBLIC OF PROPOSALS TO CAP NONECONOMIC DAMAGES OR ELIMINATE THE COLLATERAL SOURCE RULE IN MEDICAL MALPRACTICE CASES?

Proposals of this type are ill-advised. Elimination of the collateral source rule solely favors medical professionals by passing on the cost of the medical injury to another health care provider. Often, an insured person has the benefit of health or disability insurance which pays for a portion of the additional medical costs attributable to the injuries caused by a physician's negligence. Typically, the insurer will assert a lien against its insured's recovery or pursue a subrogation claim. Under proposals to eliminate the collateral source rule, the negligent physician would get a credit for the insurer's payment, and the insurer could not recover from the person who injured its insured. An obvious consequence of the loss of lien and subrogation rights by a health or disability insurer will be an increase in those premiums. Where government proposals provide such insurance, government health care costs would increase. The net result is no reduction in health care costs but a windfall benefit to the defendant medical professional and his or her insurer at the expense of the injured person.

Proposals to limit noneconomic damages deprive individuals of compensation for the consequences of medical malpractice injuries. No one has stated that such injuries are not real or severe. In fact, noneconomic injuries may far exceed the economic damages. These proposals, if enacted, would make seriously injured persons who are the least able to afford it receive less than full compensation while less seriously injured persons would be fully compensated. This would be grossly unjust.

A bottom line is whether the economic benefits to the public in reducing health care cost is significant enough to warrant depriving other members of the public—injured persons—of full and adequate compensation from those responsible for their injuries. With the cost of the entire medical-legal system constituting less than one percent of health care costs, a pertinent inquiry is whether such proposals would have any noticeable impact except upon injured persons.

Such proposals would not eliminate the less than one percent of health care costs attributable to medical professional liability since no one seriously urges that the medical profession should be immune from liability. Rather, such proposals are directed at those injured persons who are ultimately compensated. These victims of medical negligence are the subject of such proposals. Any savings in the cost of health care would be a small fraction of a percent. Thus, even on an economic analysis, such proposals, if implemented, will not have a measurable impact upon the cost of health care. Such proposals, however, would impact severely and dramatically upon the persons who are victims of medical malpractice.

SHOULD ALTERNATIVE DISPUTE RESOLUTION BE ENCOURAGED FOR MEDICAL MALPRACTICE ACTIONS?

The ABA has long supported the use of various methods of alternative dispute resolution (ADR) and was an early leader in advocating for its use. We encourage providing appropriate ADR options in a national health access proposal as an efficient means of expediting medical malpractice claims.

In 1976, the ABA co-sponsored a conference in St. Paul, MN. The conference sought to address two principal topics: "What types of disputes are best resolved by judicial action and what kinds are better assigned to another more appropriate forum?," and "Can the interest of justice be better served with processes less time-consuming and less expensive?" The conference discussions led to the appointment of a "Pound Conference Follow-up Task Force," under the chairmanship of Judge

[12] Martin L. Gonzalez, "Medical Professional Claims and Premiums 1985-1990," Socio-economic Characteristics of Medical Practice, 1992, page 23.

[13] *Defensive Medicine and Medical Malpractice*, see footnote 8.

Griffin Bell. The Task Force published a report with numerous recommendations for justice reform in August, 1976.

A principal recommendation of the report is that a variety of innovative dispute resolution techniques be explored: arbitration, mediation, revitalized and expanded small claims courts, and the concept of a "neighborhood justice center."

In 1977, when the ABA established its Standing Committee on Dispute Resolution, that subject was relatively obscure; however, during the past 16 years, the ABA through its Standing Committee and its newly established Section on Dispute Resolution, has chartered the nation's dispute resolution agenda. The Multi-Door Courthouse, school mediation and police dispute resolution programs were unknown concepts until after the ABA's 1976 Conference on Improvements in the Administration of Justice.

Today, the dispute resolution world is dramatically different. Much has happened, in part because of ABA leadership. The extensive work of the ABA is described in a document entitled the *ABA Blueprint for Improving the Civil Justice System*. Copies of the "Blueprint" are available upon request.

The ABA's House of Delegates has adopted four resolutions relevant to ADR and medical malpractice. The resolutions call for the following:

1. To promote continued use of and experimentation with ADR, both before and after filing suit, as welcome components of the justice system. (Adopted August 1989.)

2. Consistent with the attached ABA policy (Appendix D), to support the increased use of ADR by federal agencies, which included support for the recently passed Administrative Dispute Resolution Act of 1990. (Adopted August 1988.)

3. To support the use of arbitration for resolution of medical malpractice disputes under circumstances whereby the agreement to arbitrate is entered into only after a dispute has arisen. (Adopted August 1977.)

4. To support the voluntary use of arbitration so long as the parties have full knowledge that once entered into, the arbitration panel's decision is final and binding; and that arbitration panels should consist of one impartial arbitrator in "small" claims cases and three arbitrators—an attorney, a physician, and a layman in larger claims cases. (Adopted August 1976.)

5. The ABA opposes the enactment of any legislation mandating that Federal Courts adopt rules that permit local District Courts to order mandatory but nonbinding arbitration as a condition precedent to a trial before a judge or jury. (Adopted August 1994).

The ABA is concerned about achieving a more expeditious and economical resolution of medical malpractice litigation.

Voluntary alternative dispute resolution, for example, has gained acceptance as an alternative to litigation. The ABA recognizes the importance of the development and use of ADR methods other than full judicial trials for resolving legal disputes. ABA policy supports the "continued use of and experimentation with alternative dispute resolution techniques both before and after suit is filed," so long as they assure that every disputant's constitutional and other legal rights and remedies are protected. Of course, such concepts have equal validity in litigation against any defendant, and no special justification exists for being applied only in cases involving medical professionals.

The use of voluntary alternative dispute resolution techniques is consistent with the relevant policy considerations of attracting to an overburdened judicial system the independent and impartial services and expertise upon which that system necessarily depends. Besides relieving court congestion and speeding up the conclusion of cases, these alternative dispute resolution procedures are often less-expensive and less stressful than seeing a case through its normal trial path.

ABA RECOMMENDATIONS ON PUNITIVE DAMAGES

The ABA has adopted recommendations on punitive damages in tort cases that we believe can and should be implemented by the courts and legislatures at the state and not the federal level. This is in keeping with the ABA's views that the tradition of state fashioned tort principles remain fundamentally sound.States have acted during the past decade to address concerns with punitive damages. They should be permitted to continue to handle this area of the law. The ABA believes that no justification exists for exempting medical malpractice actions from the rules of punitive damages applied in tort litigation to deter gross misconduct. We believe that no disclosure of financial worth by a defendant in a tort action should be required unless there is a showing by evidence in the record or preferred by the plaintiff that would provide a legal basis for recovery of punitive damages.

The ABA believes that punitive damages are appropriate in certain tort cases, but their scope should be limited. They should not be commonplace. A threshold requirement for the submission of a punitive damages case to a finder of fact should be that the defendant demonstrated a conscious or deliberate disregard with respect to the plaintiff. The standard of proof should be "clear and convincing" evidence and not a lesser standard such as a "preponderance of the evidence".

The ABA opposes caps on punitive damages. Although rare, punitive damages are an effective means of deterring and punishing egregious conduct. Setting an arbitrary cap on punitive damages can work against the goal of deterrence.

The ABA believes that the litigation process for awarding punitive damages could be improved on the state level as follows:

(1) Pre-Trial—Appropriate pre-trial procedures should be routinely utilized to eliminate frivolous claims for punitive damages prior to trial, with a savings mechanism available for late discovery of misconduct meeting the standard of liability.

(2) Trial—Evidence of net worth and other evidence relevant only to the question of punitive damages ordinarily should be introduced only after the defendant's liability for compensatory damages and the amount of those damages have been determined.

(3) Post-Trial—As a check against excessive punitive damage awards, verdicts including such awards should be subjected to close scrutiny by the courts. The trial court should order remittitur wherever justified. Excessiveness should be evaluated in light of the degree of reprehensibility of the defendant's acts, the risk undertaken by the plaintiff, the actual injury caused, the net worth of the defendant, whether the defendant has reformed its conduct and the degree of departure from typical ratios (as reflected in the best available empirical data) between compensatory and punitive damages.

The ABA is concerned that no defendant should be subjected to punitive damages that are excessive in the aggregate for the same wrongful act. There should therefore be safeguards to prevent the imposition of redundant awards of punitive damages. The purpose of punitive damages is to punish, not to confiscate. The ABA recognizes that the principal responsibility to control excessive awards for punitive damages rests on the courts; however, state legislation may be necessary to assure more effective judicial review of punitive damage awards.

The ABA believes that in certain punitive damages cases, such as torts involving possible multiple judgments against the same defendant, a court could be authorized to determine what is a reasonable portion of the punitive damages award to compensate the plaintiff and counsel for bringing the action and prosecuting the punitive damage claim, with the balance of the award to be allocated to public purposes, which could involve methods of dealing with multiple tort claims such as consolidation of claims or forms of class actions.

Since the ABA adopted its policy relevant to punitive damages in tort cases in February, 1987, the vast majority of states has taken steps to reduce the frequency and size of punitive damages awards. In 1993, the Institute for Court Management of the National Center for State Courts devoted an issue of "The Justice System Journal" to tort issues in state courts. An article by Thomas Koenig and Michael Rustad at page 21, Volume 16, number 2 of the "Journal" entitled "The Quiet Revolution Revisited: An Empirical Study of the Impact of State Tort Reform of Punitive Damages in Products Liability" empirically documents the significant changes that have taken place in the area of punitive damages between 1987 and 1992 at the state level. Since the article was published, additional action has taken place in the states.

Thank you for giving us this opportunity to submit our views to you.

APPENDIX A.

RESOLUTION APPROVED BY THE
AMERICAN BAR ASSOCIATION
HOUSE OF DELEGATES
February 11, 1986

Be It Resolved, That

(1) The American Bar Association urges appropriate ABA entities, such as the Action Commission to Improve the Tort Liability System and the Commission on Professionalism, to continue to consult, where appropriate, with representatives of the American Medical Association and others in the health care industry, the insurance industry, state and federal governments and appropriate segments of the public with the goal of seeking a broader consensus on how more equitably to compensate persons injured in our society. The problems associated with medical professional liability are common to all areas of tort law and should be evaluated in the context of their broader implications for the tort system as a whole. The legal and medical professions should cooperate in seeking common solutions to these problems and should avoid any efforts to polarize the discussion of these problems, which would serve neither the public interest nor the interests of either profession.

(2) Consistent with these goals, the American Bar Association adopts the following principles:

a. The regulation of medical professional liability is a matter for state consideration; and federal involvement in that area is inappropriate.

b. There should be rigorous enforcement of professional disciplinary code provisions which proscribe lawyers from filing frivolous suits and defenses; and sanctions should be imposed when those provisions are violated.

c. There should be more effective procedures and increased funding to strengthen medical licensing and disciplinary boards at the state level; and efforts should be increased to establish effective risk management programs in the delivery of health care services.

d. No justification exists for exempting medical malpractice actions from the rules of punitive damages applied in tort litigation to deter gross misconduct.

e. No disclosure of financial worth by a defendant in a tort action should be required unless there is a showing by evidence in the record or proffered by the plaintiff that would provide a legal basis for recovery of punitive damages.

f. Notices of intent to sue, screening panels and affidavits of non-involvement are unnecessary in medical malpractice actions.

g. No justification exists for a special rule governing malicious prosecution actions brought by health care providers against persons who sued them for malpractice.

h. Trial courts should scrutinize carefully the qualifications of persons presented as experts to assure that only those persons are permitted to testify who, by knowledge, skill, experience, training or education, qualify as experts.

i. The collateral source rule should be retained; and third parties who have furnished monetary benefits to plaintiffs should be permitted to seek reimbursement out of the recovery.

j. Contingent fees provide access to the courts; and no justification exists for imposing special restrictions on contingent fees in medical malpractice actions.

k. The use of structured settlements should be encouraged.

l. Collection and study of data on the cost and causes of professional liability claims should be undertaken to evaluate and develop effective loss prevention programs.

RESOLUTION APPROVED BY THE
AMERICAN BAR ASSOCIATION
HOUSE OF DELEGATES

February 16-17, 1987
(Report No. 123)

Be It Resolved, That the American Bar Association adopts the following recommendations:

A. Insurance

1. The American Bar Association should establish a commission to study and recommend ways to improve the liability insurance system as it affects the tort system.

B. Pain and Suffering Damages

2. There should be no ceilings on pain and suffering damages, but instead trial and appellate courts should make greater use of the power of remittitur or additur with reference to verdicts which are either so excessive or inadequate as to be clearly disproportionate to community expectations by setting aside such verdicts unless the affected parties agree to the modification.

3. One or more tort award commissions should be established, which would be empowered to review tort awards during the preceding year, publish information on trends, and suggest guidelines for future trial court reference.

4. Options should be explored by appropriate ABA entities whether additional guidance can and should be given to the jury on the range of damages to be awarded for pain and suffering in a particular case.

C. Punitive Damages

5. Punitive damages have a place in appropriate cases and therefore should not be abolished. However, the scope of punitive damages should be narrowed through the following measures:

a. Standards of Conduct and Proof

Punitive damages should be limited to cases warranting special sanctions and should not be commonplace. A threshold requirement for the submission of a punitive damages case to the finder of fact should be that the defendant demonstrated a conscious or deliberate disregard with respect to the plaintiff. As a further safeguard, the standard of proof to be applied should be "clear and convincing" evidence as opposed to any lesser standard such as "by a preponderance of the evidence."

b. The Process of Decision

(1) Pre-Trial - Appropriate pre-trial procedures should be routinely utilized to eliminate frivolous claims for punitive damages prior to trial, with a savings mechanism available for late discovery of misconduct meeting the standard of liability.

(2) Trial - Evidence of net worth and other evidence relevant only to the question of punitive damages ordinarily should be introduced only after the defendant's liability for compensatory damages and the amount of those damages have been determined.

(3) Post-Trial - As a check against excessive punitive damage awards, verdicts including such awards should be subjected to close scrutiny by the courts. The trial court should order remittitur whenever justified. Excessiveness should be evaluated in light of the degree of reprehensibility of the defendant's acts, the risk undertaken by the plaintiff, the actual injury caused, the net worth of the defendant, whether the defendant has reformed its conduct and the degree of departure from typical ratios (as reflected in the best available empirical data) between compensatory and punitive damages. If necessary to assure such judicial review, appropriate legislation should be enacted. Opinions issued by trial or appellate courts either upholding or modifying an award should specify the factors which were considered and relied upon.

c. Multiple Judgment Torts

While the total amount of any punitive damages awarded should be adequate to accomplish the purposes of punitive damages, appropriate safeguards should be put in force to prevent any defendant from being subjected to punitive damages that are excessive in the aggregate for the same wrongful act.

d. Vicarious Liability

With respect to vicarious liability for punitive damages, the provisions of Section 909 of the Restatement (Second) of Torts (1979) should apply. Legislatures and courts should be sensitive to adopting appropriate safeguards to protect the master or principal from vicarious liability for the unauthorized acts of nonmanagerial servants or agents.

e. To Whom Awards Should Be Paid

In certain punitive damages cases, such as torts involving possible multiple judgments against the same defendant, a court could be authorized to determine what is a reasonable portion of the punitive damages award to compensate the plaintiff and counsel for bringing the action and prosecuting the punitive damage claim, with the balance of the

award to be allocated to public purposes, which could involve methods of dealing with multiple tort claims such as consolidation of claims or forms of class actions. The novelty of such proposals and the absence of any adequately tested progress for implementing require further study before an informed judgment can be made as to whether, or to what extent, such proposals will work in practice. We urge such studies. The concept of public allocation of portions of punitive damage awards in single judgment actions is also worthy of consideration to the extent workable methods of implementation may hereafter be developed.

D. Joint-and-Several Liability

6. The doctrine of joint-and-several liability should be modified to recognize that defendants whose responsibility is substantially disproportionate to liability for the entire loss suffered by the plaintiff are to be held liable for only their equitable share of the plaintiff's noneconomic loss, while remaining liable for the plaintiff's full economic loss. A defendant's responsibility should be regarded as "substantially disproportionate" when it is significantly less than any of the other defendants' for example, when one of two defendants is determined to be less than 25% responsible for the plaintiff's injury.

E. Attorneys' Fees

7. Fee arrangements with each party in tort cases should be set forth in a written agreement that clearly identifies the basis on which the fee is to be calculated. In addition, because many plaintiffs may not be familiar with the various ways that contingency fees may be calculated, there should be a requirement that the contingency fee information form be given to each plaintiff before a contingency fee agreement is signed. The content of the information form should be specified in each jurisdiction and should include at least the maximum fee percentage, if any, in the jurisdiction, the option of using different fee percentages depending on the amount of work the attorney has done in obtaining a recovery, and the option of using fee percentages that decrease as the size of a recovery increases. The form should be written in plain English, and, where appropriate, other languages.

8. Courts should discourage the practice of taking a percentage fee out of the gross amount of any judgment or settlement. Contingent fees should normally be based only on the net amount recovered after litigation disbursements such as filing fees, deposition costs, trial transcripts, travel, expert witness fees, and other expenses necessary to conduct the litigation.

9. Upon complaint of a person who has retained counsel, or who is required to pay counsel fees, the fee arrangement and the fee amount billed may be submitted to the court or other appropriate public body, which should have the authority to disallow, after a hearing, any portion of a fee found to be "plainly excessive" in light of prevailing rates and practices.

F. Secrecy and Coercive Agreements

10. Where information obtained under secrecy agreements (a) indicates risk of hazards to other persons, or (b) reveals evidence relevant to claims based on such hazards, courts should ordinarily permit disclosure of such information, after hearing, to other plaintiffs or to government agencies who agree to be bound by appropriate agreements or court orders to protect the confidentiality of trade secrets and sensitive proprietary information.

11. No protective order should contain any provision that requires an attorney for a plaintiff in a tort action to destroy information or records furnished pursuant to such order, including the attorney's notes and other work product, unless the attorney for a plaintiff refuses to agree to be bound by the order after the case has been concluded. An attorney for plaintiff should only be required to return copies of documents obtained from the defendant as condition that defendant agree not to destroy any such documents so that they will be available, under appropriate circumstances, to government agencies or to other litigants in future cases.

12. Any provision in a settlement or other agreement that prohibits an attorney from representing any other claimant in a similar action against the defendant should be void and of no effect. An attorney should not be permitted to sign such an agreement or request another attorney to do so.

G. Streamlining the Litigation Process: Frivolous Claims and Unnecessary Delay

13. A "fast track" system should be adopted for the trial of tort cases. We recommending such a system, we endorse a policy of active judicial management of the pre-trial phases of tort litigation. We anticipate a system that sets up a rigorous pre-trial schedule with a series of deadlines intended to ensure that tort cases are ready to be placed on the trial calendar within a specified time after filing and tried promptly thereafter. The courts should enforce a firm policy against continuances.

14. Steps should be taken by the courts of the various states to adopt procedures for the control and limitation of the scope and duration of discovery in tort cases. The courts should consider, among other initiatives:

(a) At an early scheduling conference, limiting the number of interrogatories any party may serve, and establishing the number and time of depositions according to a firm schedule. Additional discovery could be allowed upon a showing of good cause.

(b) When appropriate, sanctioning attorneys and other persons for abuse of discovery procedures.

15. Standards should be adopted substantially similar to those set forth in Rule 11 of the Federal Rules of Civil Procedure as a means of discouraging dilatory motions practice and frivolous claims and defenses.

16. Trial judges should carefully examine, on a case-by-case basis, whether liability and damage issues can or should be tried seperately.

17. Nonunanimous jury verdicts should be permitted in tort cases, such as verdicts by five of six or ten of twelve jurors.

18. Use of the various alternative dispute resolution mechanisms should be encouraged by federal and state legislatures, by federal and state courts, and by all parties who are likely to, or do become involved in tort disputes with others.

II. Injury Prevention/Reduction

19. Attention should be paid to the disciplining of all licensed professionals through the following measures:

(a) A commitment to impose discipline, where warranted, and funding of full-time staff for disciplinary authorities. Discipline of lawyers should continue to be the responsibility of the highest judicial authority in each state in order to safeguard the rights of all citizens.

(b) In every case in which a claim of negligence or other wrongful conduct is made against a licensed professional, relating to his or her profession, and a judgment for the plaintiff is entered or a settlement paid to an injured person, the insurance carrier, or in the absence of a carrier, the plaintiff's attorney, should report the fact and the amount of payment to the licensing authority. Any agreement to withhold such information and/or to close the files from the disciplinary authorities should be unenforceable as contrary to public policy.

I. Mass Tort

20. The American Bar Association should establish a commission as soon as feasible, including members with expertise in tort law, insurance, environmental policy, civil procedure, and regulatory design, to undertake a comprehensive study of the mass tort problem with the goal of offering a set of concrete proposals for dealing in a fair and efficient manner with these cases.

I. Concluding Recommendation

21. After publication of the report, the ABA Action Commission to Improve the Tort Liability System should be discharged of its assignment.

HEALTH CARE COSTS and TORT "REFORM"

Attached is a chart showing the percentage of increase from 1982 to 1990 in personal health care spending per capita by state. It is derived from a February 1992 report entitled "Health Care Spending - Nonpolicy Factors Account for Most State Differences," published by the General Accounting Office (GAO). The GAO report utilized 1982 data compiled by the Health Care Financing Administration (HCFA) and 1990 estimates from Lewin/ICF.

Health care costs approximately doubled from 1982 to 1990 regardless of whether a state had enacted tort "reforms" and regardless of the type of "reforms" enacted, as is demonstrated by the attached chart.

For example, based on the figures utilized in the GAO report, the three states with percentage increases estimated to be slightly lower than average -- Arkansas, Kentucky and Mississippi -- had no caps on damages in medical malpractice cases. Alabama, with a slightly higher than average estimated percentage increase, had a cap on damages. Massachusetts and California, the two states with the highest estimated personal health care costs per capita, had in place a cap on damages.

The attached chart was developed by the American Bar Association Special Committee on Medical Liability and the ABA Governmental Affairs Office. May 1993. Contact: Lillian B. Gaskin, Staff Liaison to the Special Committee (202/331-2604).

Percentage of Increase from 1982 to 1990 in Personal Health Care Costs Per Capita, State by State

*1982 RANKING/STATE**	*1982 HCFA data**	*1990 LEWIN/ICF Estimates**	*% of INCREASE***
1 Massachusetts	$1,508	$3,031	101
2 California	1,451	2,894	99
3 New York	1,417	2,818	99
4 Nevada	1,380	2,757	100
5 Rhode Island	1,351	2,707	100
6 Connecticut	1,348	2,699	100
7 North Dakota	1,325	2,661	101
8 Illinois	1,308	2,619	100
9 Missouri	1,285	2,568	100
10 Michigan	1,281	2,569	101
11 Pennsylvania	1,273	2,536	99
12 Kansas	1,271	2,548	100
13 Ohio	1,247	2,493	100
14 Maryland	1,232	2,436	98
15 Minnesota	1,229	2,480	102
16 Hawaii	1,228	2,469	101
17 Florida	1,228	2,427	98

1982 RANKING/STATE*	1982 HCFA data*	1990 LEWIN/ICF Estimates*	% of INCREASE**
18 Wisconsin	1,219	2,449	101
19 Nebraska	1,216	2,452	102
20 Colorado	1,209	2,415	100
21 Alaska	1,187	2,367	99
22 Iowa	1,176	2,351	100
23 Washington	1,165	2,311	98
24 Oregon	1,165	2,312	98
25 South Dakota	1,154	2,322	101
26 Delaware	1,153	2,268	97
27 Tennessee	1,144	2,262	98
28 New Jersey	1,115	2,224	99
29 Arizona	1,112	2,211	99
30 Texas	1,110	2,192	97
31 Louisiana	1,106	2,185	98
32 Indiana	1,101	2,201	100
33 Maine	1,091	2,175	99
34 Oklahoma	1,086	2,139	97
35 West Virginia	1,057	2,088	98

1982 RANKING/STATE*	1982 HCFA data*	1990 LEWIN/ICF Estimates*	% of INCREASE**
36 Virginia	1,054	2,076	97
37 Georgia	1,048	2,072	98
38 Montana	1,036	2,059	99
39 Alabama	1,033	2,286	121
40 Arkansas	994	1,944	96
41 New Hampshire	986	1,981	101
42 Vermont	978	1,956	100
43 Kentucky	957	1,875	96
44 North Carolina	931	1,833	97
45 New Mexico	904	1,792	98
46 Mississippi	897	1,751	95
47 Utah	896	1,784	99
48 Wyoming	873	1,756	101
49 Idaho	868	1,726	99
50 South Carolina	857	1,689	97
U.S. Average	1,220	2,425	99

* *This data was obtained from a February 1992 GAO report entitled "Health Care Spending - Nonpolicy Factors Account for Most State Differences." Note that the Lewin/ICF estimates are not directly comparable with the HCFA data because the Lewin/ICF estimates also include administrative costs for private insurance which are excluded from HCFA's data on personal health care expenditures. GAO reported that it conducted its review "in accordance with generally accepted government auditing standards." HCFA estimates that 1990 U.S. personal health expenditures per capita averaged $2,255.*

** *Rounded off to the nearest whole number.*

RESOLUTION APPROVED BY THE
AMERICAN BAR ASSOCIATION
HOUSE OF DELEGATES
AUGUST 1988

Be It Resolved, That the American Bar Association supports the increased use of alternative means of dispute resolution by Federal administrative agencies consistent with the following

A. General

1. Administrative agencies should adopt alternative methods of dispute resolution for resolving a broad range of issues. These techniques include arbitration, factfinding, minitrials, and mediation. The issues for which they may be employed include matters that arise in formal or informal adjudication, in rulemaking, in issuing or revoking permits, and in settling disputes, including litigation brought by or against the government.

2. Congress and the courts should not inhibit agency uses of the ADR techniques by requiring formality where it is inappropriate.

B. Voluntary Arbitration

3. Congress should act to permit executive branch officials to agree to binding arbitration to resolve controversies. This legislation should authorize any executive official who has authority to settle a matter on behalf of the government to agree to arbitration, either prior to the time a dispute may arise or after a controversy has matured, subject to whatever may be the statutory authority of the Comptroller General to determine whether payment of public funds is warranted by applicable law and available appropriations.

4. Congress should authorize agencies to adopt arbitration procedures to resolve matters that would otherwise be decided by the agency pursuant to the Administrative Procedure Act ("APA") or other formal procedures. These procedures should provide that:

(a) All parties to the dispute must knowingly consent to use the arbitration procedures, either before or after a dispute has arisen.

(b) The parties have some role in the selection of arbitrators, whether by actual selection, by ranking those on a list of qualified arbitrators, or by striking individuals from such a list.

(c) Arbitrators need not be permanent government employees but may be individuals retained by the parties or the government for the purpose of arbitrating the matter.

(d) Agency review of the arbitral award be pursuant to the standards for vacating awards under the U.S. Arbitration Act, 9 U.S.C. §10, unless the award does not become an agency order or the agency does not have any right of review.

(e) The award includes a brief, informal discussion of its factual and legal basis, but neither formal findings of fact nor conclusions of law.

(f) Any judicial review is pursuant to the limited scope-of-review provisions of the U.S. Arbitration Act, rather than the broader standards of the APA.

(g) The arbitral award is enforced pursuant to the U.S. Arbitration Act but is without precedential effect for any purpose.

5. Factors bearing on agency use of arbitration are:

(a) Arbitration is likely to be appropriate where —

(1) The benefits that are likely to be gained from such a proceeding outweigh the probable delay or costs required by a full trial type hearing.

(2) The norms which will be used to resolve the issues raised have already been established by statute, precedent, or rule, or the parties explicitly desire the arbitrator to make a decision based on some general standard, such as "justice under the circumstances," without regard to a prevailing norm.

(3) Having a decisionmaker with technical expertise would facilitate the resolution of the matter.

(4) The parties desire privacy, and agency records subject to disclosure under the Freedom of Information Act are not involved.

(b) Arbitration is likely to be inappropriate where —

(1) A definitive or authoritative resolution of the matter is required or desired for its precedential value.

(2) Maintaining established norms or policies is of special importance.

(3) The case significantly affects persons who are not parties to the proceeding.

(4) A full public record of the proceeding is important.

(5) The case involves significant decisions as to government policy.

C. Mandatory Arbitration

6 Arbitration is not in all instances an adequate substitute for a trial-type hearing pursuant to the APA or for civil litigation. Hence, Congress should consider mandatory arbitration only where the advantages of such a proceeding are clearly outweighed by the need to (a) save the time or transaction costs involved or (b) have a technical expert resolve the issues.

7 Mandatory arbitration is likely to be appropriate only where the matters to be resolved —

(a) Are not intended to have precedential effect other than the resolution of the specific dispute, except that the awards may be published or indexed as informal guidance;

(b) May be resolved through reference to an ascertainable norm such as statute, rule or custom;

(c) Involve disputes between private parties; and

(d) Do not involve the establishment or implementation of major new policies or precedents.

8 Where Congress mandates arbitration as the exclusive means to resolve a dispute, it should provide the same procedures as in Paragraph 4 (b) - (g) above, except that judicial review should be pursuant to the Administrative Procedure Act but with the courts bearing in mind the purposes to be gained by arbitration.

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

On behalf of its 80,000 members, the America Academy of Family Physicians is pleased to submit this statement for the record of the hearing held on S. 454, the "Health Care Liability Reform ad Quality Assurance Act of 1995.

The American Academy of Family Physicians is extremely concerned about the impact of the growing medical professional liability crisis on the cost and availability of health care services. Skyrocketing medical malpractice insurance premiums have and will continue to result in significant increases in health care costs and reduced access to essential services, particularly in underserved areas. While much attention has been focused on the so-called "high-risk" specialties and procedures, the problem is pervasive and affects all patients and physicians in all specialties. In a 1992 Gallup poll of generalist physicians, 93 percent said that fear of lawsuits leads them to prescribe tests that are otherwise unnecessary.

The existing medical liability system is extraordinarily expensive, inherently wasteful and inefficient. Physician and hospital liability insurance premiums totalled $9.2 billion in 1991,and have been growing at four times the rate of inflation. It is estimated that left unchecked, defensive medical practices will add between $15 billion and $30 billion per year to the cost of health care. Despite these extraordinary costs to the health care sector, as well as to the legal system, the plaintiff, and the defendant, almost two out of every three medical liability claims nationwide are closed without any payment to the claimant. Moreover, among bona fide victims of medical negligence, all empirical studies confirm that two claimants who have suffered the same injury in the same circumstances will receive wildly different awards. Finally, only 43 cents of every dollar spent in processing ad paying claims reaches injured patients. Attorneys' fees account for most of the other 57 cents.

What produces these capricious results—and accounts for the system's run-away costs—are jury-awarded damages for "pain and suffering." Such damages are highly subjective, ad it is that subjectivity that contributes to much of the unpredictability and inconsistency in awards. Reducing the unpredictability and eliminating the potential for unreasonably high awards would remove some incentive for plaintiffs and their lawyers to "play the lottery" and would promote more expeditious settlement of meritorious cases. The federal Office of Technology Assessment (OTA) concurred in its September, 1993 report, noting that a reasonable ceiling on damages for pain and suffering is the most effective way to contain medical liability costs.

The Academy has long supported legislation to address the medical liability problem without placing limits on a patient's right to be compensated for monetary losses (medical and rehabilitation expenses, additional household expense, lost wages, and so forth) and without reducing the deterrent effect of malpractice liability. We are particularly pleased to see the following provisions of S. 454:

Tort reforms that are federally mandated and apply to all states, including: modification of the common law collateral source rule to end the double recovery of damages, allowing periodic payment of future damages over $100,000, limitations on attorneys' contingency fees, and joint and several liability reforms to assign proportionate liability among the defendants in a case;

Statute of limitations, so that a claim must be filed within two years from the date that the alleged injury should reasonably have been discovered;

Requirements that states establish alternative dispute resolution (ADR) systems, which may include arbitration, mediation, early offer and recovery mechanisms, or other systems designed to quickly resolve meritorious claims and relieve the civil court system of those that are not; and

Requiring a certificate of merit to accompany all health care liability actions brought to court.

The Academy also urges the committee to amend the Alternative Dispute Resolution requirements so that at the completion of the resolution process, if the one of the parties to the dispute chooses to challenge the outcome in court, and the decision rendered in court is less favorable than that in the resolution process, the filing party pays all legal fees. Such a "loser pays" rule is a much more forceful mechanism than an affidavit for ensuring that only meritorious disputes are brought to the court system. Without fairly strong disincentives, the entire ADR system becomes merely a bureaucratic process on the way to court.

Furthermore, the certificate of merit provision should be clarified to require that the affidavit be written by a specialist who *possesses knowledge and expertise and practices in the same medical specialty as the defendant.*

An essential addition to S. 454 is cap on non-economic damages. As mentioned above, in a September, 1993 report, the Office of Technology Assessment reported that a reasonable ceiling on noneconomic damages is the most effective way to contain medial liability costs. In addition, a 1993 Lewin-VHI report estimated that the

nation could save $25 billion in health care costs by eliminating defensive medical practices. We understand that some advocates question the real potential for savings of this magnitude, arguing that "defensive" medical practices have become the accepted standard of care for may clinical conditions, and that so long as medical injury compensation remains a tort-based system, physicians will not abandon these practices. However, it is the Academy's strong contention that tests and procedures that are not medically indicated are not only excessively expensive, but are contrary to the physical well being and appropriate medical management of the patient. Every medical test and procedure carries with it a small but statistically measurable risk of adverse reaction or outcome, and the thousandfold defensive procedures performed by physicians greatly increases the probability that a few patients will suffer needless adverse events.

The Academy concurs that it will take a long time for physicians to adjust their practice patterns once reform is enacted. However, innovations in the health care market place such as managed care ad outcomes research will help reduce medically unnecessary services. The Academy notes that critics of reform see in managed care additional opportunities for medical mischief. In a managed care environment, the argument goes, the practice incentives are more likely to result in undertreatment, so that the accountability afforded by the medical tort system is more necessary than ever. It is imperative that Congress understand that we are not talking about eliminating liability for medical negligence. On the contrary, there is ample evidence that consumers are already disadvantaged by the current medical malpractice system, and several of the reforms proposed in S. 454 will make it easier for truly injured parties to access the system. What we are taling about is the reduction of incentives for individuals and their lawyers to file truly spurious medical lawsuits on the chance that a sympathetic lay-jury might make them millionaires. Experience in California suggests that even when a $250,000 cap on noneconomic damages is in place, patients who file valid claims for severe injuries will still be compensated with large awards.

If Congress is ever to reach agreement on medical liability reform, then it must move beyond the issue of cost to the real issues of access and the consequences of a runaway medical liability system on the availability of critical health care services. In this regard, family physicians bring unique experience to the debate. As the principal providers of health care services to disadvantaged and underserved populations, family physicians see daily the contributions of the existing malpractice system to the problems that define these groups.

For example, in rural areas, inner cities, and economically depressed communities—which have been the last to attract qualified medical care providers—a virtual exodus of obstetric providers has occurred. Family physicians are a critical source of obstetric care in these underserved areas, providing about two thirds of the obstetric services available in rural areas.

Yet family physicians delivering obstetric services pay malpractice insurance rates that are two to three times higher than those of their counterparts who do not practice obstetrics. These rates pose a especially difficult burden on rural family physicians because they generally have fewer obstetric patients among whom to spread the cost. Also, physicians who provide backup for Certified Nurse Midwives have to pay additional malpractice premiums.

The results are predictable. In a recent survey of AAFP members, 1 out of 4 family physicians who previously provided obstetrical services reported having discontinued those services due to the cost or unavailability of medical liability insurance, while another 10 percent limited the type of obstetrical care they provide. Approximately 62 percent of family physicians have given up obstetrics altogether. As a result, in rural areas pregnant women are unable to deliver at nearby hospitals where the obstetric unit has been shut down and are forced to travel greater distances to obtain care. Indigent women are also affected as obstetric providers limit their participation in high risk care or decline to participate in public programs because reimbursement rates fail to cover liability premium costs. For women who already are statistically less likely to obtain early and regular prenatal care, ad who are at considerably greater risk of a poor pregnancy outcome, the medical malpractice problem has exacerbated already chronic access barriers. For these reasons, the Academy applauds Sec. 110 of S. 454, which would raise the standard of evidence necessary to sue physicians who provide services during labor or delivery if the physician did not previously treat the woman for the pregnancy.

Finally, the Academy is gravely concerned that S. 454 contains a provision that would open the National Practitioner Data Bank to public use. While we understand the impulse to make information about provider competence and claims history available to health care consumers, the fact is that the information contained in the data bank is difficult to interpret accurately and is of little or no predictive value

with respect to the quality of care provided by the physicians listed in it. A large number of medical liability settlements reported in the data bank are nuisance suits that were settled by physicians in order to avoid the financial and emotional costs of litigation. That a suit was settled is no indication of the merits of the claim. In cases of actual negligence, studies have found that poor quality of care in any particular instance does not imply incompetence with respect to that condition or procedure.

Moreover, the brief descriptions of events contained in the data bank do not permit full understanding of the circumstances of the alleged injury. Finally, as the Physician Payment Review Commission suggests, "Permitting public access to NPDB information would be likely to adversely affect the underlying processes that generate the information. There are anecdotal reports that more physicians are refusing to settle cases in order to avoid being reported to the NPDB. These effects would be greatly exacerbated if the NPDB were opened to the public".

The Academy appreciates the opportunity to submit these comments for the record. As the Committee moves toward mark-up of S. 454, we hope you will consider the modifications proposed herein.

The CHAIRMAN. That concludes today's hearing.

[Whereupon, at 12:08 p.m., the hearing was adjourned.]

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